

**Mental Hygiene to Civil Rights : MIND and the Problematic of
Personhood, *c.* 1900 to *c.* 1980**

Jonathan Paul Toms

University College London

**Ph.D
History of Medicine**

UMI Number: U602543

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI U602543

Published by ProQuest LLC 2014. Copyright in the Dissertation held by the Author.
Microform Edition © ProQuest LLC.

All rights reserved. This work is protected against
unauthorized copying under Title 17, United States Code.



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Acknowledgements

I would like to thank the Wellcome Trust for funding and support to complete this thesis. Also the mental health charity MIND and its head office staff for their generosity in providing me access to their archives and library facilities. The late Edith Morgan, very kindly gave me access to her personal archives and gave up her time to discuss the history of MIND with me.

I would particularly like to thank my tutor Professor Roger Cooter who gave me support, criticism, advice and encouragement. Rhodri Hayward also read and provided critical responses to the thesis as it developed.

I would also like to thank Barbara Abrahams who, without either of us realising it, helped to set me off in this direction many years ago now.

Finally, I'd like to thank Judy Moore for an engagement with me and this thesis that is beyond words. And last, but definitely not least, Heidi, who, despite having to put up with endless hours of me researching, discussing and writing this thesis, has remained deeply honest, thoughtful, and above all, kind – just as she has always been.

'Society would have *every one* come to his right indeed, but yet only to that right which is sanctioned by society, to the society-right, not really to *his* right. ... According to the liberal way of thinking, right is to be obligatory for me because it is thus established by *human reason*, against which *my reason* is "unreason". Formerly people inveighed in the name of divine reason against weak human reason ; now, in the name of strong human reason, against egoistic reason, which is rejected as "unreason". And yet none is real but this "unreason". Neither divine nor human reason, but only your and my reason existing at any given time, is real, as and because you and I are real.'

Max Stirner, *The Ego and His Own* (London: A.C. Fifield, 1912) [1845] p268-9.

Table of Contents

	Page
INTRODUCTION	1-20
CHAPTER ONE	
Prelude - Emotions Suppressed : Moral Therapy Extended to the Community	21-38
Charity Social work as Moral Therapy	21-26
Moral Character : Living With the Grain of History	26-34
Mental Deficiency Legislation	34-38
CHAPTER TWO	
Emotions Shaped and Contained	39-94
Mental Hygiene : Institutional Establishment and Altered Problematic	39-44
The Ubiquity of Emotional Irrationality	44-47
Moral Therapy Extended : A Matter of Public Health	47-53
The Multiple Uses of the Terminology of Adjustment	54-58
'Man' Without a History is a Threat to the Moral Order	59-65
A New Dispensation : The Ordering of Society by the Ordering of Minds	65-75
Emotional Development Situated Within the Hierarchy of Minds : Some Effects on Care and Treatment	75-94
CHAPTER THREE	
Emotions Situated in the Web of Relationships : 1	95-145
Introduction	95-99
Situating Emotions in the Web of Relations	99-103
Shifting Towards Confronting the Dynamics of Relationships But Continuing Mental Hygiene's Pre-war Agenda	104-111
Emotional Relationships and Theorizing on Children's Residential Care	112-120
The Impact of Child Care Theorizing on Mental Deficiency	120-125

Engagement With Emotional Relations : Experimental Approaches at Northfield Therapeutic Community, the Civil Resettlement Scheme and the Social After-Care Service.	126-144
---	---------

CHAPTER FOUR

Emotions Situated in the Web of Relationships : 2	145-184
--	---------

Introduction	145
The International Congress on Mental Health	146-163
Mental Deficiency : '50,000 Outside the Law'	163-184

CHAPTER FIVE

Emotions Situated in the Web of Relationships : 3	185-252
--	---------

Introduction	185
Part One : Mental Hygiene's Functionalist Agenda Retained	186-206
Mentally Healthy Relational Integration Versus Mentally Unhealthy Isolation	186-201
Moral Therapy Continues	201-206
Part Two : The Undermining of Mental Hygiene	206-252
History, The Backbone of Mental Hygiene, Fragments and Transforms	206-221
Healthy Emotional Relationships Versus Institutionalization	221-227
Emotional Relations, Institutionalization and Power Relations : the Mental Hygiene Problematic Lays the Ground for the Later Rights Strategy	227-252

CHAPTER SIX

Emotional Relations Consolidated	253-309
---	---------

Introduction	253
The Right Strategy : A 'Classical' Civil Libertarian Break with MIND's Past?	254-258
Why Assert the Civil and Social Status of Mentally Ill People?	259-266

MIND's Rights Problematic : A Question of Liberty and
Choice Versus Regulations and Restriction? 266-267

MIND's Rights Strategy Represents an Opposition of
'Institutionalization' Versus Healthy Emotional Relations and
Social Integration 268-274

The Goal of Healthy Emotional Relations and Social
Integration Retained; Professional Expertise and Power
Relations Questioned 274-280

MIND Promotes Therapeutic Communities 280-292

Mental Handicap 292-310

Introduction 292-293

From Institutionalization to Integration : the Basis of
Rights for People Termed Mentally Handicapped 293-299

Institutional Provision is Emotionally Disabling 299-301

Developmental History Reasserted? 301-306

Fighting Hierarchies of Mind : Emotional Relationships
Matter 307-309

CHAPTER SEVEN

**Emotions Suppressed : Nikolas Rose and 'Strong Social
Constructionism'** 310-349

Introduction 310-311

Rose's Criticism of Rights 311-318

A 'History-less' Self is a Threat to the Moral Order 318-324

Social Construction Versus 'Strong' Social Construction
325-330

History Cannot be Introduced as an Independent Means to
Show that 'the Self' is Constructed and the 'Significant' Ways
in Which this Takes Place. 330-339

The Privilege Given to Intellectual Knowledge Delegitimizes
Emotional Experience 340-343

Whose Subjectivity? 343-349

Introduction

Imagine yourself looking at a large oil painting. It stretches from floor to ceiling on the wall in front of you. On it is displayed a scene from a busy market square. Full of people of different descriptions, all living their lives, but frozen here in time and space. Who are they? What are they doing? How would you interpret them? Perhaps you would categorize them into groups with common characteristics. What are their motives? Perhaps you would interpret a look on a face, a smile, a frown, a look of fear.

But imagine now that you walk towards the picture. You don't stop at the canvas and the frame that contains it but continue on into and within the frame itself. As you do so you find the scene simultaneously shifting from two dimensions to three and from stasis to animation. Noise, colour and movement confront you. And most of all voices. These people are alive and speaking back at you. You realize that your knowledge has only ever been one-way and that your looking through the frame from outside has delimited what is available for you to see and here. It is not that you have thrown away the frame and exposed the world in its totality. You have entered within the frame itself. No longer the sole interpreter; you are both the interpreter and the interpreted. Can you ground your knowledge? Can you resist the urge to step back outside the frame? It was safer then wasn't it?

This is the kind of process that this thesis seeks to describe. It attempts to trace the changing nature of a way of framing, conceptualizing, and acting upon subjective

experience as a problem to be solved. I shall return to this. But first I want to discuss why I have adopted this approach.

This study began as an attempt to understand why a voluntary organization working closely with psychiatrists appeared to radically shift its position at the turn of the 1970's and adopt a role as a pressure group campaigning for patients' rights. Between the 1940's and the 1980's the concept of the mental patient was transformed. By the latter decades of this period there took place an apparent breakdown in the consensus between psychiatry and society and a transformation of patients into clients. From the early 1970s MIND, the largest and most influential charity organization working in the field of mental health, pronounced itself a campaigning organization working to secure the civil, legal, and social status of mental patients. Academics working in the field of mental health and the social sciences have frequently cited MIND as of crucial importance to the repoliticisation of, both mental health policy, and the concept of the mental patient in the 1970's and 80's. MIND's legal rights campaigning has been attributed to its adoption of an external discourse of civil rights and, indeed, many commentators have characterized such work as a continuation of nineteenth-century civil libertarian activity in the field of care for the mentally disordered.¹ This period has therefore been conceived as a radical break in the history of the organization, dividing it from its earlier role as an 'establishment' organization, promoting 'mental hygiene' and working closely with both the government and the psychiatric profession.

¹ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990's* (London: The Athlone Press, 1993); Sedgwick, *Psycho Politics*, p213-4; Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Oxford University Press, 1987), p4; Philip Bean, *Mental Illness Changes and Trends* (London: John Wiley & Sons Ltd, 1983).

But radical breaks in history are always worth questioning. This description of civil rights versus psychiatry seemed to me too straightforward. Health and citizenship have always been intimately associated in the western liberal democratic tradition. Notions of citizenship are, moreover, constantly being negotiated in society. Citizenship has no more been a static concept since the nineteenth-century than have correlative notions of rights been homogenous. In fact there was a fundamental difference between the civil rights approaches of the nineteenth-century and MIND's critiques in the 1970's and 80's. The former critiques concentrated primarily on the protection of the sane from wrongful certification and detention.² The latter attempted to protect the rights and raise the civil status of mentally disordered, and mentally handicapped people themselves.³

This assumption of a radical break in MIND's history and, the associated impression that the organization was colonized by an external discourse of civil libertarianism, directs attention away from medical goals and strategy and how they might interact with civil liberties and notions of citizenship. After all the very fact that an important organization with a history of working alongside elements of the psychiatric profession *did* adopt a civil rights strategy suggests that there was some interrelation. Why did MIND come to focus upon the individual 'rights'; the civil and social status of people termed mentally disordered and mentally handicapped in the 1970's? What was it about conceptualizations of their subjective experience that had changed?

² Clive Unsworth; *The Politics of Mental Health Legislation* (Oxford: Oxford University Press, 1987), p29-30 and footnote 64; Anne Rogers and David Pilgrim; *Mental Health Policy in Britain: A Critical Introduction* (London: MacMillan Press Ltd, 1996), p52

³ Throughout this thesis I use the terms of categorization used at the time. People then termed mentally handicapped are now termed learning disabled. I emphasize, here, that these categorizations are, just that, categorizations. They are not the people they refer to.

The title 'MIND' was, in fact, adopted as an appellation for the National Association for Mental Health (NAMH). This organization was officially founded in 1946, although it actually operated from 1942, under wartime conditions, as the Provisional National Council for Mental Health (PNC). The organization acted as a charitable body working closely with psychiatrists and the government. It provided residential services, educational courses for medical professionals and more general information for the public. The organization was a prominent institutional proponent of one significant psychiatric strategy from its formation. This was the movement for mental hygiene that was influential in Britain from the early decades of the twentieth-century through to the 1950's and 60's. The mental hygiene movement promoted psychology and psychiatry as the expert means through which the mental health of the individual could be secured and maintained. It sought to educate the population into healthy ways of living, to promote strategies for prevention of mental illness and to provide efficient treatment for that which could not be prevented. Its most significant institutional embodiments were, the National Council for Mental Hygiene, the Tavistock Clinic, the Central Association for Mental Welfare, and the Child Guidance Council. Membership overlapped between these organizations. Amongst the most prominent were, the psychiatrists Hugh Crichton-Miller, J.R. Rees, H.V. Dicks and Emanuel Miller, who were all associated with the Tavistock Clinic, but also various of the other organizations. Other important psychiatrists included R.G. Gordon, D.R. MacCalman and William Moodie, all of whom were significant figures in child guidance. Amongst other notable personalities were the psychologist Cyril Burt, and the psychoanalyst Susan Isaacs.

In order to understand how a 'rights' based approach was adopted by an organization historically committed to a strategy of mental hygiene I have tracked back in time to review the development of mental hygiene itself. Thus this history is broader than a history of MIND, though the organization is central to many of the developments I elaborate. But it is neither a history of MIND nor of the mental hygiene movement. Instead I wanted to understand how conceptualizations of patients' subjective experience had changed to the extent that an organization working for mental hygiene could adopt a rights strategy to defend their civil and social status. This thesis is not an examination of the wider social, political and cultural context in which such changes took place. Many informative works have been published which provide this, both for psychiatry in general, and for some areas of mental hygiene. What I have done in this thesis is to analyze and describe these changes from the inside out. My reasons are twofold. Firstly, I wanted to examine what the effects of confronting emotional experience were for the authority of mental hygiene. How did this engagement manifest itself and what were its consequences? I wanted to see how, and in what ways, MIND's rights strategy embodied a shift from the mental hygiene conceptualization of emotionality and subjective experience. Secondly, I wanted to trace this engagement between mental hygiene's knowledge and practice, and the subjective experience of patients, in order to contest an influential version of social constructionism. This contends that medicine, and what are called the 'psy' disciplines, have been pre-eminent in what is construed as a construction of subjective experience. (I discuss this constructionist approach later in the introduction). As a means to achieve these aims I traced the way in which mental hygienists framed and acted upon subjective experience in terms of mental health and disorder. In essence this amounts to tracking a way of looking at, and acting upon, subjective experience

as a problem to be solved. In the text I refer to this loosely as a problematic⁴, or a frame of reference, or a particular conceptualization. Looking at mental hygiene in this way in fact revealed it to be akin to an earlier practice, which became influential in the late eighteenth and early nineteenth century. This was known as moral treatment or moral therapy. These associations are important to my argument. I relay them below.

The innovations termed moral therapy were associated in Britain with reformers such as William Battie at the London asylum, St Lukes, Francis Willis in Lincolnshire, the Quaker 'Retreat' at York, and John Conolly's later work at Hanwell Asylum in Middlesex from 1839. Much has been written about this lunacy reform movement and its application of moral treatment but it remains a practice not easily defined.⁵ Moral therapists generally attempted to eschew physical force and excessive restraint. Their treatment claimed to be a pragmatic approach utilizing whatever brought about positive change in the patient. But as both Andrew Scull and Roy Porter have pointed out, this was no 'kindness for kindness sake'.⁶ At root it was an attempt to apply reasonable and responsible 'minds' in a direct manner upon the mad, in order to

⁴ Ted Honderich (ed) *The Oxford Companion Guide to Philosophy* (Oxford: OUP, 1995). Alan Hunt describes this notion of a problematic as, '... contained in every statement of a frame of reference or a theoretical proposition; it is more than the statement of a problem or a question in that the selection of a particular focus excludes or relegates other foci and thereby presents a potential solution within itself.' Alan Hunt, 'Perspectives in the Sociology of Law', in Pat Carlen (ed), *The Sociology of Law* (University of Keele: Sociological Review Monograph 23 1976), p22, cited in Clive Unsworth; *The Politics of Mental Health Legislation*, p118.

⁵ Anne Digby, 'Moral Treatment at the Retreat, 1796-1846', in W.F. Bynum, Roy Porter, Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol2* (London: Tavistock Publications, 85) 52-72. Anne Digby, *Madness, Morality and Medicine: A Study of York Retreat 1796-1914*, (Cambridge: Cambridge University Press, 1985) Andrew T. Scull, *Museums of Madness: The Social Organization of Madness in 19th Century England* (London: Allen Lane, 1979) Roy Porter, *Mind Forg'd Manacles: Madness and Psychiatry in England from the Restoration to the Regency* (London: Athlone Press, 1987), p206-222.

⁶ Andrew T. Scull, *Museums of Madness: The Social Organization of Madness in 19th Century England* (London: Allen Lane, 1979), p68; Porter, Roy, 'Shaping Psychiatric Knowledge: The Role of the Asylum' in, Roy Porter (ed) *Medicine in the Enlightenment* (Amsterdam: Clio Medica, 1995) 255-273, p263.

encourage a reactivation of the 'will' and therefore of responsible powers of self-control. Influential pioneers of education developed similar ideas of moral therapy for people termed 'idiots'. These educators argued that idiots could be 'improved' through special methods of teaching. As with moral therapists working in lunacy, educators such as Seguin attempted to reform the idiot by activating a capacity for self-control. Seguin sought to develop the 'will' over the animalistic and uncivilized impulses of idiots. 'He will not, but we will for him', wrote Seguin: 'The first condition of being free is willpower and obedience'.⁷ Such educators emphasized sensory and muscular development in conjunction with a structured environment of imitation, repetition and reward. Schools and institutions were to be kept small with an emphasis on moral discipline but not physical force. Again, as with moral therapy for lunatics, physical force was seen as only constraining irresponsible and uncivilized behaviour. Moral treatment, in contrast, would engage the 'will' in order to cultivate mature and useful conduct.

In all this, as Scull emphasized, moral treatment echoed contemporary changes in approaches to the working population generally. Rapid industrialization entailed a need to discipline the workforce both externally and internally through the internalization of norms of attitude and conduct. Moral Treatment in the asylum mirrored such conceptualizations in its attempts to reform rather than simply restrain. The reactivation of the 'will' and internalization of norms were to bring about self-restraint and responsible behaviour. As Scull noted, the market made success or failure the responsibility of the individual, similarly moral treatment was intended to show the mad, through reward and punishment, that only by asserting responsible

⁷ Cited in Joanna Ryan and Frank Thomas, *The Politics of Mental Handicap* (Harmondsworth: Penguin, 1980), p95.

self-control could they regain themselves.⁸ Hard work, self-discipline and social responsibility were the self-professed hall-marks of the urban bourgeoisie from which the likes of Samuel Tuke derived, and hard-work, self-discipline and social responsibility were to be the hall-marks of the self-reform of the mad.

The project for mental hygiene, that became institutionally established between the wars held to a similar problematic. But this problematic was extended beyond application to the detained individual and outwards to society as a whole. It was a vision of mental health and disorder that encompassed the moral order of society. Mental health and disorder were intimately linked with the establishment of a moral self safely situated within the wider moral order. Mental hygienists emphasized the nature of mental disorder as having an 'intimate relationship with the body'.⁹ As J. Bernard Rae put it mental health was a matter of 'right relation'. 'The body', he wrote, 'must be related to the mind, the mind to the individual, and the individual to others'.¹⁰ 'Man' needed to be taught how to control his instincts and emotions.¹¹ In general mental hygienists accepted the psychologist William McDougall's view that disorders of conduct were derived largely from emotions that were excessive or defective.¹² In effect then mental hygiene was a 'neo-moral therapy'. The influential psychiatrist J R Lord, for instance, characterized mental hygiene as 'the dominance of reason over emotion in the moulding of personality in such a fashion as to bring out the finest traits of human character'.¹³ Reason was to dominate emotions. Personality was to be

⁸ Andrew T. Scull, *Museums of Madness: The Social Organization of Madness in 19th Century England* (London: Allen Lane, 1979), p68.

⁹ See *Tenth Report of the National Council for Mental Hygiene 1932* (London: NCMH, 1933) p5.

¹⁰ J. Burnett Rae, 'Psychotherapy: Its Place and Implications', *Mental Hygiene Bulletin* 3 (1931) 1-7, p7.

¹¹ Letitia Fairfield, 'Crime and Punishment', *Mental Hygiene* 4 (1931) 17-20, p18.

¹² See *Mental Welfare* 6 1 (1925), p22.

¹³ Cited in National Council for Mental Hygiene, *News Bulletin* July 1930, p13.

moulded by the correct application of reason. Excessive emotional substrates were to be taken control of. Mental hygienists particularly stressed confronting mental disturbances *before* they reached full insanity. In so doing they paid increasing attention to what were called 'borderline' and 'borderland' cases. Those who inhabited the 'borderland' between normality, on the one hand, and mental deficiency and mental illness on the other, were considered to have failed to adjust to the demands of the environment. They needed a sympathetic understanding and 're-education to a new attitude of mind'.¹⁴ The 'normal man', asserted the psychiatric social worker St Claire Townsend, met emotional stress and disappointment with recognition of the need to adjust himself to his new situation; the 'abnormal man' exhausted himself with 'excessive emotions and anxieties'.¹⁵ St Claire Townsend's view of outpatient treatment for 'borderland' neurotic cases consisted essentially of attempting to strengthen their 'will'. Understanding, encouragement, sternness, reason; if the patient's 'will-power' was insufficient to deal with excessive emotions then the trained social worker could use her expertise to animate it for the client. Here again we have a clear echo of Seguin's moral treatment: 'If he will not we will for him'. For St Claire Townsend, the social worker was to embody the 'balance' that the 'unstable and unbalanced' had lost.¹⁶

Looked at in terms of how it viewed subjective experience and mental disorder, mental hygiene, can be seen to share the central elements of moral therapy. Essential to moral therapy thus broadly understood, is the application of one particular type of 'mind' over another. The former mind is all that the latter is not. Conceiving of itself

¹⁴ St Claire Townsend, 'The Value of Social Service in the Out-Patient Treatment of Mental Disorder', *Mental Welfare* 6 2 (1925) 29-35, p30.

¹⁵ St Claire Townsend, 'The Value of Social Service', p30.

¹⁶ St Claire Townsend, 'The Value of Social Service', p34-5.

as rational and objective it feels confident in asserting its own reasonableness and responsibility. It is this reasonable mind that, having isolated 'character' and conduct considered to constitute a problem to self and others, seeks to reactivate and inculcate objective self-control. Only thus can the 'problem' mind be saved from unreasonable subjectivity and indulgent sentiment. In the assertion of a right to influence the internalization of norms upon others, this reasonable mind assumes an authority that is a perpetual judgement. It is, in effect, a kind of 'one-way' reasoning. It brooks no reply other than one that accepts the definition of its nature and thus the need for reform and emulation.

With this conceptualisation of mental hygiene as a neo-moral therapy I set about tracing how it was expressed through the twentieth century. I found that several shifts in configuration could be discerned. Up until the repercussions of the final alteration played themselves out, mental hygiene held to a form of conceptualisation and practice still recognizable as a version of moral therapy. However, as these shifts progressed, they could be seen, ultimately, to simultaneously subvert the authority of mental hygiene, while substantially informing the rights approach adopted by MIND from the 1970's. This thesis outlines these shifts and their consequences for the authority of the psychiatric strategy known as mental hygiene and its conceptualisation of those people who were its targets.

Briefly, these shifts were: First, the employment of outlines and categorizations of history. These provided a means of authority to support the extension of the moral therapy problematic beyond application to the detained individual and outwards to society as a whole. I stress that, from the earliest discernable appearance of mental

hygiene as a movement, history was deployed as an authority capable of informing mental hygienists' descriptions of, and prescriptions for, mental health and adjustment. Originally, this took the form of generally accepted delineations of stages of progress and evolution. This was expressed in terms of the progressive evolution of civilization through the reciprocal development of societies and individual minds. These descriptions of the past were renditions of it as progressive. They provided a means to define 'healthy adjustment' and deviations from it. My concern with history in this thesis is not limited to the fact that mental hygienists deployed a rendition of the past as progressive however. When I speak of history I mean the rendition of the past through its categorization, classification and interpretation. The issue here is that categorizations and classifications of the past provided a means to support mental hygienists' determinations of personhood; its significant aspects; its healthy adjustment and deviations, and what constituted efficient citizenship. It is not the rendition of the past as made up of progressive stages that is key. That is just one authoritative description of the past. Rather, it is the more general fact that the past is invoked as an element of authority used in the moral definition of personhood and its 'deviations'. This historical rendition of personhood is an abstraction; it hangs over individuals while maintaining that this is *truly* what they are. Directed at people in this way, as a prescriptive moral definition, it provides an added element of the moral therapy problematic, an added element of authority, surveillance, and definition. In effect, the past is given a countenance so that people in the present may be provided with one.

Secondly, I identify a later shift entailing a reconfiguration, from seeking to subdue and ultimately neutralize recalcitrant emotion, to attempting to shape and craft it in

order to bring about adequate socialization and mental adjustment. This, in fact, entailed the addition of a further stratum to the progressive stages of the past deployed by mental hygienists. Stages of emotional development were superimposed upon those of intellectual and societal development. Mental hygienists' particular confrontation with subjective experience was one of attempting to isolate that which was dangerous to self or others. From here, they attempted to assert a self-appointed, 'reasonable' mind, in order to save the other from unreasonable emotionality or indulgent sentiment.

In consequence my concentration on subjective experience tracks this attention to emotionality. I do not seek to show how what was seen as emotionality was 'constructed', but what happened to the authority of mental hygiene as its framing of emotional experience shifted from seeing it as rooted in the individual body to manifest in the ebb and flow of relationships. The definitive nature of emotions is altogether another question. Indeed, one professor of psychology has recently remarked:

A psychologist who works on the emotions recently boasted that 'there are now dozens of distinguishable theories of emotionality, hundreds of volumes devoted to that topic, and tens of thousands of articles dealing with various aspects of human affect.' This is depressing news since psychologists know little more about emotion than does the layman.¹⁷

¹⁷ Stuart Sutherland, *Irrationality: The Enemy Within* (London: Constable, 1992), p130.

Nevertheless, like him, I accept that emotionality is an inextricable and vital aspect of subjective experience. But, beyond this, I do not seek to define it. In fact, difficulties of definition point to an important factor that I highlight in this thesis. Emotionality, and indeed personal subjective experience, defy not only scientific, but also historical, certitude. Subjective experience appears to 'flow' and confound systematic replication.

Lastly, I describe a further, and crucial shift of mental hygienists' problematic. This ultimately came to undermine the authority of mental hygiene itself. In essence there was a switch from perceiving and acting upon emotions as rooted in the individual to engaging with them as located in the flux of human relationships. This challenged the hierarchy and authority implicit in mental hygiene. When mental hygienists began to construe emotionality as manifest in a dynamic relational milieu, they started a process that ultimately revealed their neo-moral therapy as a power relation.

Knowledge and treatment were not just relations of therapy but also of power and authority. From standing outside the frame; asserting a perpetual judgement; objectively determining character and conduct that was irrational or unreasonable; deploying their 'reasonable' minds in order to influence the internalization of norms; mental hygienists found that they had walked into their own frame of reference. Their knowledge, their activities, and their own emotional experience became part of the problematic. The attitudes and approach of mental hygienists and mental health personnel were now considered as potentially detrimental to, as well as productive of, mental health. Mental hygienists' expertise and authority came into question. At the same time, and for the same reasons, patients began to be able to speak outside of the definitions imposed upon them. Their subjective experience came (incompletely and

sporadically) to constitute a knowledge and authority that might counter that of the therapist. Knowledge and treatment were revealed as a power relation; it was this development that substantially informed MIND's turn to a policy of defending the rights of mental patients.

My description of this transformation of a problematic opens up a further area of analysis and critique for this thesis namely, a very different view of subjective experience, psychiatry and power, to that maintained in constructionist accounts of medicine, psychiatry and 'the self'. The main exponents of this constructionist view are Nikolas Rose and David Armstrong. They have deployed and developed Michel Foucault's work in a way that can be described as 'strong social constructionism'. But their constructionism is of a particular character. They claim that medical and psychological knowledge and practices permeated society during the twentieth century to the extent that these practices have been pre-eminent in the construction of our very 'selves'.¹⁸ According to them, medical and psychological expertise does not simply treat illness and seek to understand health, but actually constitutes the significant means through which 'subjectivity' is constructed. (In this thesis I term Rose and Armstrong's approach 'strong' social constructionism as a means to differentiate it from other approaches). This, in effect, takes social constructionist approaches and adds a further twist to them. Rather than showing that *knowledge* about 'the self', which has become accepted as 'given', or 'taken for granted', is

¹⁸ Nikolas Rose, *Governing the Soul: The Shaping of the Private Self*, (London: Routledge, 1989); Nikolas Rose *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939* (London: Routledge and Kegan Paul, 1985); David Armstrong; *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983); David Armstrong, *A New history of Identity: A Sociology of Medical Knowledge* (Basingstoke: Palgrave, 2002).

amenable to social explanation, they maintain that 'the self' itself is socially constructed.

I contest this influential assertion. I take aim, in particular, at Rose's work. This is partly because it is the most sustained example of its kind. But it is also because Rose himself, entered the political fray regarding the strategy of rights that MIND came to employ. As we will see, an engagement with his criticism of rights necessitates an engagement with his more fundamental description of the construction of 'the self'.

I have two principal areas of disagreement with this constructionist view of 'the self'. The main one is its engagement with subjective experience and emotionality. In a paper written with Peter Miller, about one institution involved with the strategy of mental hygiene, Rose maintained the 'constitutive role of knowledge' and associated practices in the construction of the 'emotional and subjective economy of the citizen'.¹⁹ In Armstrong's version, this is neatly summed up in the sentence, 'It is the thought that constructs the thinker and the deed that constructs the doer.'²⁰ It is implied that this is all there is to personhood. But how can this encompass the totality of subjective experience? Even if we only limit this to emotionality, how can such a statement grapple with its elusive, subtle and penetrating qualities? If the only way we can 'know' anything is via objective intellectual knowledge then this immediately delegitimizes any other prospect of knowing. The answer is presumed before asking the question. The source of knowledge about emotional experiences thus remains external to those experiences. They may be the objects of study but not as a

¹⁹ Peter Miller and Nikolas Rose, 'The Tavistock Programme', *Sociology* 22 2 May 1988 171-192, p174 and 175.

²⁰ David Armstrong, *A New history of Identity: A Sociology of Medical Knowledge* (Basingstoke: Palgrave, 2002), p197.

source of knowledge in themselves. Intellectual knowledge reigns supreme. It denies any other knowledge: There is *only* intellectual knowledge – therefore emotional experience *must* be constructed.

Human existential experience, it seems, has become – in these self-consciously intellectual texts at least – a 'love that dare not speak its name'. But, as I have emphasized, emotional experience defies, not only scientific, but also historical, certitude. Whatever emotions are they cannot simply be gainsaid as 'constructions'. And, in contrast to the constructionist approach, I have attempted to at least recognize that this is the case. What must be emphasized, I believe, is that epistemology cannot be separated from subjectivity; that is, from experience. Privileging objective intellectual knowledge is, therefore, an illegitimate attempt to separate epistemology from subjective experience. This application of intellectual knowledge to subjective experience, to my mind, ends up valuing, not the 'experience', but only the analysis. Models of 'the self' are, after all, just that, models of 'the self'.²¹ I am not a model.

A second area of disagreement is with the manner in which constructivists use history. Habitually they deploy, categorize and delineate the past as a means to inform their argument that 'the self' is constructed. As with mental hygiene the issue here is that these renditions of the past are used to support descriptions of personhood. Although this constructionist rendition does not attribute any progressive nature to the past, it nevertheless invokes it as an element of authority, in the definition of personhood. And, in the case of Rose, the constructed image of personhood conjured up is closely

²¹ For a similar view to mine on this see, Mark S. Jenner and Bertrand O. Taihe, 'The Historiographical Body' in, Roger Cooter and John Pickstone (eds) *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic Publishers, 2000) 187-200, p193-194.

related to his fears concerning the fragmentation of the moral order.²² Moreover, this use of history clearly begs questions about constructivism's own construction of the past. I argue that, just as with mental hygiene, this historical rendition of personhood is an abstraction, which hangs over individuals at the same time as it purports to be what they *truly* are.

This thesis is not, then, another attempt to show how the 'power of psychiatry' has fabricated our 'emotional economy' as a part of a remorseless and one-way construction of our very 'selves'.²³ Instead, it is an attempt to describe how, by paying attention to the details of emotional experience, mental hygienists brought about consequences for the power of psychiatry. I have tracked the history of a changing problematic and some of its ramifications. This history, I contend, places not only mental hygiene and the civil rights approach to mental health, but also, 'strong social constructionism', in a new and revealing light.

Chapter one provides a prelude to the main argument. It suggests a link between nineteenth century moral therapy and the beginnings of the mental hygiene movement in the campaign for the reform of provision for mental deficiency. The chapter also introduces the themes of, history, emotionality, citizenship, and their relation to the moral order.

Chapter two deals with the period between the wars when mental hygiene as a movement was institutionally established. It introduces and discusses the first shift in

²² I deal with this in the final chapter.

²³ The reference to the 'power of psychiatry' alludes to, Peter Miller and Nikolas Rose, *The Power of Psychiatry* (Cambridge: Polity Press, 1986).

the problematic that framed and acted upon emotional experience in terms of mental health and disorder. Unlike moral therapy which had attempted to subdue, diminish and ultimately neutralize recalcitrant emotion, interwar mental hygiene attempted to shape emotionality in accordance with a delineated history of individual and societal development.

The following three chapters analyze a further reconfiguration of the mental hygiene problematic – a crucial change that affected the authority on which mental hygiene was based. In essence this reconfiguration entailed a switch, from perceiving and acting upon emotions as rooted in the individual, to engaging with them as located in the flux of human relationships. Mental hygienists' programmatic intentions remained the same, but this shift in analysis disrupted the 'one-way' application of neo-moral therapy. Simply put, mental hygienists walked into their own problematic. Their activities, knowledge and concepts were now a part of the problematic itself. I term this 'the emotional-relational problematic' and trace out some key consequences. The one-way reasoning of self-appointed objective minds isolating unreasonable subjectivity began to subvert itself. This process was, however, fitful, intermittent and ambivalent. Nevertheless, mental health personnel were now part of the dynamic emotional processes that they sought to manipulate. Staff needed to become aware of their own emotionality as well as that of their patients. Since emotionality was understood to be situated in the relational milieu, there was an increasing belief that attunement to emotional sensitivities should entail an eschewal of 'unfeeling' and hierarchical authority. The problematic drew attention towards the details of emotional relationships in the present and, partly as a consequence, disrupted the delineated histories of individual and societal development on which mental

hygienists based much of their expertise of 'adjustment' to 'mature' citizenship. There was an associated, though ambivalent, injunction to listen more directly to the recipients of therapy's own views of their emotional experience and its history. Mental hygienists and mental health personnel found themselves considered in terms of the mental hygiene problematic – their attitudes and approach could be, not only productive of, but also detrimental to mental health. These chapters also elaborate the ways in which these consequences provided areas of engagement and antagonism between mental hygiene and civil libertarianism. They show that central elements informing MIND's rights campaigning were expressed under the rubric of mental hygiene as early as the 1940's.

Chapter six shows how the emotional-relational problematic and its ramifications informed MIND's campaigning. In essence MIND continued the analytic imperative developed under the rubric of mental hygiene and shed the notion of unquestioned medical expertise. What was retained was a view of mental health and illness as manifest in an emotional-relational milieu; what was discarded was the self-evidence of expert knowledge about this manifestation. I discuss these factors in the context of Rose's attack on MIND's rights approach, and show that the basis of his representation and criticism of it is misconceived.

The final chapter more fully confronts the strong social constructionist approach. It discusses Rose's constructivist view of 'the self', and his attack on the strategy of rights, in terms of my account of the mental hygiene problematic, its reconfiguration and consequences. I argue that, ironically, his social constructionist approach has strong similarities with mental hygiene's original one-way moral therapy problematic. It is a history that appears to be preoccupied with the moral fidelity of the populace.

It is but another construction of history that engages with emotion only in terms of the latter's crafting and fabrication. Ultimately, it represents just another 'truth' about our existential 'selves' that allows no response from 'us', other than one that accepts the definition of our 'nature' that it supplies.

Chapter One

Prelude- Emotions Suppressed: Moral Therapy Extended to the Community.

Charity Social Work as Moral Therapy

The sociologist Robert Castel has described how nineteenth-century moral therapists sought to negate history. According to him the classification and ordering of their institutions was an attempt to produce an enclosed realm in which only the moral therapist's reasonable and unyielding mind would hold sway. A realm in which the 'intrusion of history' could be negated in order to provide a *tabula rasa* upon which might be inscribed the pure 'will' of the therapist.¹ But, if this is the case, then the extension of moral therapy outwards to the wider community entailed history's resurrection and deployment as part of its power. The broadening of moral therapy outside the asylum set out a classification and ordering of minds grounded in a particular knowledge of developmental time. History was co-opted as part of the authority of the modern moral therapist.

¹ Robert Castel, 'Moral Treatment: Mental Therapy and Social Control in the Nineteenth Century' in, Stanley Cohen and Andrew Scull (eds), *Social Control and the State: Historical and Comparative Studies*, (Oxford: Martin Robertson, 1983) 248-266, p256-8.

The Influence of British Idealism.

Contemporary historians have long emphasized the significance of the metaphors of 'developmentalism' and 'evolution' to Victorian society.² These metaphors became increasingly important to notions of social progress and history in the nineteenth century. Much of this mediated debates about the tensions between the notions of social progress and social cohesion. T.H. Green, the acknowledged leader of British Idealism, confronted these tensions by recasting debates about the relationship between individuals and the state.³ He emphasized the engagement of citizens in an active construction, both of society, and of themselves.⁴ Green employed aspects of Hegelian idealism to argue that human personality was a reproduction of the Divine Spirit. Individuals were part of the self-revelation of God through historical time and social institutions. For Green the unfolding of human history entailed the subordination of 'man's' animal self, through his rationalization and moralization⁵ Human personality was, therefore, both a product and cause of human development. But the development of human personality could not be separated from the development of social life. 'The self' could only be truly conscious of itself through its consciousness of others. For Green, 'the self of which a man thus forecasts the fulfillment, is not an abstract or empty self. It is already affected in the most primitive forms of human life by manifold interests, among which are interests in other

² John. W. Burrow, *Evolution and Society: A Study in Victorian Social Theory*, (Cambridge: Cambridge University Press, 1966). Peter J. Bowler, 'The Changing Meaning of "Evolution" ', *Journal of the History of Ideas* 36 (1975) : 95-114.

³ For biographies of the major British Idealist philosophers see, David Boucher (ed) *The British Idealists* (Cambridge: Cambridge University Press, 1997) p xxxiv-xliii.

⁴ Thomas H. Green, *Lectures on the Principles of Political Obligation* (London: Longmans, Green & Co., 1924) p43-48; Andrew Vincent, 'T.H.Green and the Religion of Citizenship' in, Andrew Vincent (ed) *The Philosophy of T.H. Green* (Aldershot: Gower, 1986) 46-81.

⁵ Thomas H Green, *Lectures on the Principles of Political Obligation*, p1-25.

persons.⁶ This conception of individuals and society allowed Green to promote a revised liberal view of citizenship and rights. For Green the bearers of rights were individuals but their social citizenship was a necessary condition of this. If human beings could not exist without society, it followed that the community could make claims upon individuals. Both individual people and the social community were participants in human social development through time. Rights were the means to self-realization and therefore the bestowal of rights was an enabling act of the ethical state. On the basis of this view, Green limited the full bestowal of rights to 'persons' in the moral rather than the abstract sense. By 'persons' he meant those possessed of a 'personality'- a rational 'will'. As Green put it, 'the capacity which man possesses of being determined to action by the conception of such a perfection of his being as involves the perfection of a society in which he lives.'⁷

Other late nineteenth-century idealist and New Liberal thinkers incorporated and developed these views. Such theorists reconfigured the concept of natural rights in order to support greater social intervention. The Oxford philosopher David G. Ritchie argued that true individual liberty could only exist by means of the state. To him, if individual liberty meant 'absence of state action', then 'the most miserable of savages or the most wretched of factory-children before the Factory Acts, would be the models of 'free' human beings.'⁸ Ritchie was strongly influenced by evolutionary theory and his views, he claimed, marked a transition from 'Individualist to Evolutionist Utilitarianism'.⁹ He saw moral character as a dual process of

⁶ Thomas H Green, *Prolegomena to Ethics*, (Oxford: Oxford University Press, 1890), p210.

⁷ Thomas H. Green, *Lectures on the Principles of Political Obligation*, p46.

⁸ David, G Ritchie, *Studies in Political and Social Ethics* (London: Swann Sonnenschein & Co., 1902), p57.

⁹ David, G Ritchie, *Natural Rights: A Criticism of some Political and Ethical Conceptions*, (London: George Allen and Unwin, Third edition, 1916), p101.

development. In part it was a conscious adoption of the habits most useful to the welfare of the community, and in part, it was a product of natural selection.¹⁰ Instead of traditional individualist natural rights Ritchie developed the utilitarian idea of 'the greatest happiness of the greatest number' into the idea of the 'common good' understood as 'the highest development of individual capacities compatible with the coherence and continuance of the society as a whole.'¹¹ For Ritchie it was the 'Bible of history' that provided both the motor of evolutionary change and the means of rational understanding through which civilized people could 'rise above the mere blind processes of nature.'¹² Morality was of a social and evolutionary character. There was therefore a continuity of moral causation. Social evolution was a rational historical process and civilized rational understanding of it would enable society to operate within the laws of nature.¹³

The Charity Organization Society.

British idealist philosophy, with its rendering of history as rational and progressive, provided a theoretical foundation for the work of Charity Organisation Society (COS). This organization, founded in 1869, represents the most prominent example of late Victorian organized philanthropic charity. Historians and social scientists have debated the extent of the COS's influence upon philanthropic practice in general, but its leaders influence on public opinion and political policy making remains largely

¹⁰ David, G Ritchie, *Darwin and Hegel*, (Swann Sonnenschein & Co., 1893), p62-3.

¹¹ David, G Ritchie, *Studies in Political and Social Ethics*, p62.

¹² David, G Ritchie, *Studies in Political and Social Ethics*, p113.

¹³ David, G Ritchie, *Natural Rights*, p285-6.

undisputed.¹⁴ It was primarily the leaders of the COS who sought for philanthropic social work, a role as domestic moral therapy for the 'socially inefficient'.

In fact a number of the COS's leaders were prominent idealist philosophers in their own right.¹⁵ Bernard Bosanquet, for instance, had been a pupil of T. H. Green's. His reinterpretation of Green's idealism sought to synthesize opposition to excessive state intervention into social life with a mix of Hegelian and Rousseauian concepts of the state as the 'general will'.¹⁶ An historical understanding of the development of moral character was a central aspect of this synthesis. The state, for Bosanquet, was the means to the 'good life'. But it could not produce this through compulsory measures. The 'good life' was a morally mature life and this could not be promoted in individuals by force. To attempt to do so would, he argued, only create passivity and actually lower moral character.¹⁷ Instead, Bosanquet believed, the state's role was to remove the barriers to the good life. But, based on his notion of the 'general will', Bosanquet provided an even wider definition of the state than Green. For Bosanquet, the 'general will' was embodied in social institutions such as schooling, housing, and even the family.¹⁸ It was in the family, the community, and popular associations that citizenship was believed to be nurtured. Within these institutions correct habits of self-reliance would be engendered through which people could aspire to the highest forms of moral character. This view was united with Bosanquet's depiction of the

¹⁴ For a general discussion of the influence of the COS see the introduction to, Jane Lewis, *The Voluntary Sector, The State and Social Work in Britain: The Charity Organisation Society / Family Welfare Association since 1869*, (Aldershot: Edward Elgar, 1995).

¹⁵ The main figure here was Bernard Bosanquet, but also espousing idealist views were, Bosanquet's wife Helen Bosanquet (nee Dendy), Charles S. Loch, Octavia Hill and Edward Dennison.

¹⁶ Peter P. Nicholson, *The Political Philosophy of the British Idealists: Selected Studies* (Cambridge: Cambridge University Press, 1990), p199-205; James Meadowcroft, *Conceptualizing the State: Innovation and Dispute in British Political Thought 1880-1914* (Oxford: Oxford University Press, 1995), Chapter Three 113-166.

¹⁷ Bernard Bosanquet, *The Philosophical Theory of the State* [1899] 4th ed (London: MacMillan, 1951) p 176 and p180.

¹⁸ Bernard Bosanquet, *The Philosophical Theory of the State*, p140 and p173.

historical components of human individuality. Human individual personality was both determined by, and productive of, historico-social development.¹⁹ The state and the community were part of the web of relationships within which the individual's personality became manifest. It followed to Bosanquet that rights of citizenship could only be recognized as powers to enable the development of human capacities.

Moral Character: Living with the Grain of History.

This vision of the moral nature of individual and society, revealed through the ongoing rational unfolding of history, informed the COS's approach to what was called 'social inefficiency'. The COS affirmed an earlier political economist depiction of destitution as essentially a matter of moral character. On this view generalized state intervention could only exacerbate the problem. But the COS claimed that 'scientific charity' could discriminate between those people who were the recalcitrant 'residuum' and those capable of a restoration to good citizenship.²⁰ As we have seen, Bernard Bosanquet in particular linked the historical development of character to evolutionary development. For him both the social character of civilization and the moral character of the individual were founded through the process of natural selection. The gradual human accrual of rational self-consciousness actually produced the possibility of harmonious relations based upon the common good.²¹ It

¹⁹ Bernard Bosanquet, *Social and International ideals: Being Studies in Patriotism*, (London: MacMillan, 1917), p270-301; Bernard Bosanquet, *The Philosophical Theory of the State*, p168.

²⁰ Sandra M. Den Otter, *British Idealism and Social Explanation: A Study in Late Victorian Thought* (Oxford: Clarendon Press, 1996), p69-70, p101 and p182-3.

²¹ Sandra M. Den Otter, *British Idealism and Social Explanation: A Study in Late Victorian Thought* (Oxford: Clarendon Press, 1996), p98-101.

followed from this that indiscriminate intervention to support the 'feckless' or 'immoral' undermined the positive process of evolution.

The COS developed, what amounted to domestic moral therapy, for those whose 'character' and efficiency it believed could be raised. By the end of the nineteenth-century, along with a derivative organization, the National Association for the Care of the Feeble-Minded (NACF), it was also agitating for legislation to provide social control for people termed 'feeble-minded' whom it was now believed constituted the vast bulk of the dangerous 'residuum'.²² These people were grouped together with other 'mentally deficient' people categorized as 'idiots' or 'imbeciles' for whom there already existed some limited institutional provision. Pressure for the creation of institutions for these latter people, earlier in the century, had been associated with transformations in work and family life related to industrialization and far reaching demographic change. Similar pressures informed the agitation at the turn of the twentieth-century which pressed for state intervention. But, in addition, the introduction of compulsory elementary education had revealed large numbers of children who appeared unable to benefit from the provision of mass education.²³ Partly as a consequence, those people already labeled 'idiots' and 'imbeciles' were now supplemented by the new, and numerically far larger categorization of people; the 'feeble-minded'.

Here, then, we have deployed a particular interpretation of a generally accepted hierarchical conceptualization of history as a foundation for the structure of contemporary society. An historical classification of human societies and character,

²² Aphra L. Hargrove, *Serving the Mentally Handicapped* (London: NAMH, 1965), p11.

²³ Gillian Sutherland, *Ability, Merit, and Measurement: Mental Testing and English Education 1880-1940*, (London, 1984)

in terms of ascending developmental stages, provided a mirror through which order and classification could be asserted in the present. Delineated classifications of people could, on this interpretation of history, be represented as groups that had deviated from such development. Moreover, the unification of idealist conceptions with Social Darwinism allowed a continuity to be drawn between individualist intervention aimed at raising moral character and intervention aimed at control and segregation.

Engagement with Emotionality.

Closely associated with this philosophy of character linked to progressive history was the development of 'friendly visiting' to individual families. This was intended as a means to re-engage the character and sense of duty of those paupers not irrevocably part of the 'residuum'. Through such theorizing the ambit of 'moral therapy' was extended from people institutionalized as lunatics outwards to the wider masses in society. From the end of the eighteenth-century moral therapists had eschewed the simple incarceration and control of lunatics. Instead they had sought to use pragmatic approaches in order to engage the 'will' and incite the lunatic to reassert his or her powers of rational self-control. From the later nineteenth-century COS caseworkers similarly sought to avoid excessive resort to containment under the Poor Law. They too professed to use rational principles in order to reassert a person's objective will and a self-maintaining character. But the theorizing of the COS, differed through its reliance upon a teleology of historical development as the glue that held together their hierarchical description of society. They emphasized the necessity of creating the correct relationship with clients in order to raise such people to an acceptable standard

of citizenship.²⁴ In keeping with their idealist notions of the individual's reciprocal relationship with both society and the state, they promoted a notion of 'reciprocity' in charitable work. But, despite the undeniable emphasis on real social engagement with the underprivileged that this term implied, it was, nevertheless, founded upon an hierarchical understanding of history and social citizenship that was anything but reciprocal in any sense of equitable mutual exchange. Indeed the concept of reciprocity mirrored the commercial exchange of the marketplace; a marketplace in which the COS's clients were already preconceived to have been found wanting.²⁵ This conception of reciprocity can be related to Bernard Bosanquet's idealist concentration upon 'duty and place'. This described societal development in terms of a hierarchy of 'place' and 'function'; each human character finding self-realization within an idealist notion of society as an organic whole differentiated into duties and functions that expressed the common good of the community.²⁶

The close association between idealist and Social Darwinist thought is explicit in the COS's theorizing about the nature of the development of character and of the casework relationship. Jane Lewis has shown how Helen Bosanquet used G.H. Stout's psychology to explain the way 'man' was distinguished from lower animals by his progressive wants.²⁷ Where lower animals were prevented from progressive development by the determining role of their instincts, man followed not instincts but his progressive wants. This enabled the rational pursuit of interests to develop. Some people, however, were too satisfied with the basics of eating, drinking and sleeping.

²⁴ Jane Lewis, *The Voluntary Sector, The State and Social Work in Britain: The Charity Organization Society/ Family Welfare Association since 1869* (Aldershot: Edward Elgar, 1995), p33-38.

²⁵ Jane Lewis, *The Voluntary Sector, The State and Social Work in Britain*, p30-31.

²⁶ Bernard Bosanquet, *The Philosophical Theory of the State*, p191-5. See also, Bernard Bosanquet, *Social and International Ideals*, p158. For a discussion and elaboration of the idea of 'duty' and 'station' see, F.H. Bradley, *Ethical Studies*, (Oxford: Clarendon, 1927).

²⁷ Jane Lewis, *The Voluntary Sector, The State and Social Work in Britain*, p41.

In terms of idealist thinking, these people had, in effect, deviated from progressive history. Their failure to develop progressive wants led them to be ruled by their 'habits' much as instincts ruled animals. For Helen Bosanquet, however, habits could be trained and educated. It was thus the duty of the social worker to correct bad habits and raise individuals to a better standard of character. History itself had a progressive character. In effect the social worker was to bring this to bear, so that these people could have their own characters brought into accordance with it. Only through the actualization of such good character could a sense of duty and 'emulation of social superiors' result.²⁸

Such a vision of a hierarchy of the character of minds, associated with 'place' and 'function' in society, occluded consideration of other factors. Class or gender, for instance, were ignored as potentially determining factors in the construction of this apparently historically ordained social and moral order. But this vision also counter-posed the apparently rational and objective form of progressive change to the 'retarding' or 'arrested' elements in society that were driven by subjectivity and emotional irrationality. Beatrice Webb, of the Fabian Society jibed that C.O.S. social work activity was 'sentimental' and inefficient. But the C.O.S. itself argued that it stood for 'scientific' charity; targeted relief through general survey and specific examination in order to encourage self-sufficiency. Charity itself had to be disciplined. It must be objective and organized. And, as one of the leaders of the C.O.S, C.S. Loch put it: 'Organisation implies order and method, sacrifice for a common end, self-restraint'.²⁹ This conviction that charity social work should be rational and objective was counter-posed to indulgent and emotional charity. The

²⁸ Jane Lewis, *The Voluntary Sector, The State and Social Work in Britain*, p41.

²⁹ Jane Lewis, *The Voluntary Sector, The State and Social Work in Britain*, p26.

leitmotifs of organized social reform and intervention; science, control, rationality, objectivity, discipline, were delineated by what they were not; emotionality, irrationality, subjectivity, ill discipline, indulgence. Such counter-points placed the women, who made up the bulk of the C.O.S's caseworkers, in an ambivalent position. Male leaders of the C.O.S feared that their female volunteers were too idealistic and becoming too involved with the lower classes. Bernard Bosanquet, for example, chastised that such women had become 'victims of their senses', who had been 'carried away by the first impression of reasoned pity'.³⁰ These women, claimed Bosanquet, were 'indulging' themselves. And in indulging their own unrestrained emotional responses they were indulging the very people that required the inculcation of attitudes and behaviour that would enable them to become responsible for their own fate. What Bosanquet was claiming, in effect, was that these women social workers were being too subjective. Social work should on the contrary be objective. The role of civil society was to express the civilized application of reason to social problems, to divide the 'deserving' from the 'undeserving' poor, and to instill acceptable standards of behaviour and character.

As for the people categorized as mentally deficient, now preeminently the group associated with the 'residuum', the campaign for social control and segregationist policies was cognate with a more general national debate about racial degeneration in society. Overcrowding in institutions and an increasingly apparent shortage of provision fueled focus upon mentally deficient people. But a consequence of this concentration of people in large numbers at asylums was that it provided the opportunity and means for analytical studies and classifications of abnormality to be

³⁰ Fred Powell, *The Politics of Social Work*, p27.

developed. What transpired were categorizations of difference and inferiority. Partly in response to the perceived failure of nineteenth century moral therapist aspirations to reform idiots, asylum superintendents increasingly described apparent developmental and hereditary inferiorities as causes of mental deficiency. Frequently the two were combined to show that deficient heredity and poor moral character reinforced one another.³¹ Developments in anthropology were incorporated with these theories. By the later nineteenth century almost all anthropological interpretations of human history believed race to be a crucial factor in human behaviour.³² Mentally deficient people became the survivals of an arrested individual and social development. They were the relics within civilized society of pre-civilized races. Increasingly, medical professionals and voluntary organizations worked in association with one another with regard to mental deficiency. Doctors such as A.F. Tredgold (the consulting physician to the NACF), W.A. Potts and E.O. Lewis adopted and applied the term 'arrested development' as a medical definition for mental deficiency in general. It was in this context that John Langdon-Down had classified one group of mentally deficient people as 'Mongolian' and a clear case of degeneration. Other racial categorizations now followed. A.F. Tredgold even claimed to have observed Negroid, Grecian, Egyptian and American –Indian types of mentally deficient people.³³

Firmly identified with the incorrigible 'residuum' as they were, the feeble-minded could not, it was argued, respond to casework intervention in the family aimed at promoting responsible habits through emulation and education. A medical definition

³¹ Joanna Ryan and Frank Thomas, *The Politics of Mental Handicap*, p102-109; Mark Jackson, *The Borderland of Imbecility: Medicine, Society and the Feeble Mind in Late Victorian England* (Manchester: Manchester University Press, 2000), p96-111.

³² Peter J. Bowler, *The Invention of Progress*, p39.

³³ Joanna Ryan and Frank Thomas, *The Politics of Mental Handicap*, p105.

of 'arrested development' suggested that their poor habits and character could not be improved through such domestic intervention. Without surveillance, segregation and expert treatment in model environments their sexual, violent, and criminal potentialities would constitute a threat to themselves and to the health and fitness of the community. Mental deficiency thus became reified as a social contagion with a 'tendency to perpetuate itself by creating an environment inimical to the development of normal mentality'.³⁴

Notions of promiscuous sexuality and loose 'uncivilized' family relationships ascribed to pre-civilized races and contemporary 'savages' were similarly attributed to mentally deficient people. The close association in the Victorian mind of a conflict between reason and nature was allied with what was portrayed as a volatile and at times florid emotionality. The feeble-minded were represented as expressive of a more 'primitive' sexuality, allied to a volatile emotionality unchecked by rational moral character, and made all the more dangerous by their presence within the social community.³⁵ But such expression of feelings was located in the pre-civilized substrates of their 'arrested' minds. Erratic and unpredictable emotions were associated with crime, sexual perversion and societal pollution. The unpredictableness and apparent irrationality of behaviour associated with an emotionality that was 'arrested' back in a 'true state of nature' necessitated confrontation and control. Indeed, because these were only 'brute' feelings they did not need to be taken into account to the extent appropriate for more civilized and developed people. This fear of mentally deficient

³⁴ These are words are, in fact, those of the Report of the 1934 Departmental Committee on Sterilization, cited in, 'Report of the Departmental Committee on Sterilization', *Mental Welfare* 15 1 (1934) 1-7, p7. This report recommended the provision of 'voluntary' sterilization for feeble-minded people.

³⁵ For a description of some of these fears in the United States, see James W. Trent Jr., *Inventing the Feeble mind: A History of Mental Retardation in the United States* (Berkeley: University of California Press, 1994), Chapter Five.

people's florid emotionality and its potential consequences was coupled with a general lack of attention to the sensitivities inseparable from these people's emotions. An underlying support for this connection was history. To be 'sensitive', to be 'moved' by 'sentiment' was held to be the prerogative of rational civilized, 'mature' people; the result of progressive history. Only through the development of intellect might one truly be able to produce a 'refined' and humane sensitivity. The emotional experiences and expression of people determined developmentally 'arrested' were of a different order.

Mental Deficiency Legislation.

The Radnor Commission was appointed in 1904 in response to this agitation as well as general fears of racial degeneration. Its members included; W.H. Dickinson M.P., chairman of the NACF, Dr. A.F. Tredgold (who acted as the Commission's consulting physician), Dr W.A. Potts, and C.S. Loch, the Secretary of the COS. The Commission calculated that there were about 66,000 feeble-minded people at large in the community, who required treatment beyond mere supervision in the community. Its conclusions were fully in keeping with the segregationist proposals of social reformers. The final report claimed that the feeble-minded people's 'wayward and irresponsible lives are productive of crime and misery, of much injury and mischief to themselves and to others, and of much continuous expenditure wasteful to the community.'³⁶ The solutions, it asserted, were ascertainment, supervision and detention.

³⁶ Clive Unsworth., *The Politics of Mental Health Legislation*, p157.

Despite widespread support, and the backing of both the Reports on the Poor Law, the government was slow to legislate. In response successive private members Bills were tabled by the NACF and the C.O.S. The NACF founded a Committee to pressurize for action which garnered support from the newly formed Eugenic Reform Society, a number of voluntary organizations working in the field, and prominent public figures including the Archbishops of York and Canterbury.³⁷ Various pamphlets and articles were produced as propaganda. In 1908 A.F. Tredgold, published what was to become the standard textbook on the subject, *Mental Deficiency*. And in a 1911 article for the *Eugenics Review*, entitled 'The Future Progress of Man', Tredgold reasserted the link between the progress of civilization and the control and segregation of the feeble-minded.³⁸

A Mental Deficiency Act was eventually passed in 1913 with a hefty majority. As Clive Unsworth has noted, the Act embodied a 'dramatic intensification of intervention in respect of particular categories of the mentally disordered ... [and] was strikingly coercive in emphasis and philosophically...'³⁹ As Mathew Thomson has described it, the Act 'automatically targeted individuals who were the subject of moral, social, or eugenic concern ... [and] had the potential to regulate the moral, social, and eugenic boundaries of citizenship.'⁴⁰ Under the Act all county and county boroughs in England and Wales were to provide institutional provision, arrange community supervision, and ascertain the local population of people deemed mentally

³⁷ Aphra Hargrove, *Serving The Mentally Handicapped* (London: NAMH, 1965), p18.

³⁸ A. F. Tredgold, 'The Future Progress of Man', *Eugenics Review* 3 April 1911- January 1912 94-117.

³⁹ Clive Unsworth., *The Politics of Mental Health Legislation*, p151-2.

⁴⁰ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870-1959*. (Oxford: Clarendon Press, 1989), p247.

defective.⁴¹ The Act also founded a Board of Control to oversee the whole of the mental health system.⁴²

The progress of legislation met resistance from only a few 'old style' Liberals and traditionalist Conservatives. The radical Liberal M.P. Josiah Wedgwood offered the most outspoken and sustained opposition to the legislation and the series of Bills that had presaged it. His resistance has been described as classic civil libertarianism and is worth noting here because the later attempt by MIND to assert the civil and social rights of mentally disordered people has been portrayed as following this same discourse.

Wedgwood bitterly fought the coercive nature of the proposed legislation especially its provisions for surveillance and ascertainment.⁴³ He correctly recognized that the proposals would largely target the working classes, was outspoken about the eugenic aspects, and attacked the overt moralistic judgements they contained, particularly as they affected women.⁴⁴ But Wedgwood was in by far the minority. Other Liberals charged that old formal concepts of liberty were out of date. Frederick Cawley argued, for instance, that mentally deficient people were actually the victims of an abstract concept of liberty, 'that at present is represented by being in and out of the casual wards, the maternity wards and the prisons.'⁴⁵

⁴¹ Mathew Thomson, *The Problem of Mental Deficiency*, p217.

⁴² Mathew Thomson, *The Problem of Mental Deficiency*, p77-8.

⁴³ HofC Debs, July 19th 1912, p703-7, and p713-4.

⁴⁴ HofC Debs, June 10th, 1912, p644, July 19th 1912 p710, July 29th 1913, p435-6, p455.

⁴⁵ HofC Debs, July 19th 1912, p732, cited in, Clive Unsworth., *The Politics of Mental Health Legislation*, p160.

For the purposes of this thesis, a number of elements are notable about Wedgewood's opposition. He was alert to the class and gender prejudices inherent in the proposals, as well as the power of self-appointed experts over the indefinite detention and day-to-day existence of people they diagnosed feeble-minded. At the same time he thought that the government should make residential provision for those people termed feeble-minded who needed it. But this was to be provided on a voluntary basis, in which people could choose when to stay and when to leave.⁴⁶ In my opinion, these views were largely sound. But when Nikolas Rose brought his strong constructionist theorizing to bear on MIND's later rights approach, he described the classic civil libertarian approach only in terms of a negative protection of the individual from interference. In his view

Psychiatry was constituted as a discipline in the same transformation of social and intellectual rationality that gave birth to the individual free to choose. The very same social, political and intellectual forces that inscribed the slogans of the rights of the individual upon their banners in the late eighteenth and early nineteenth centuries also invented all those disciplinary mechanisms for the systematic management of individuals through actions targeted upon the soul.⁴⁷

In other words, like the psychiatric system, civil libertarianism did not liberate anyone, but simply 'constructed' interiorized, autonomous, individuals. For Rose, the designation of an inviolate personal space cannot be a diminishment of forms of

⁴⁶ HofC Debs, May 28th, 1913, p245-8.

⁴⁷ Nikolas Rose, 'Law, rights and psychiatry', in Peter Miller and Nikolas Rose (eds) *The Power of Psychiatry* (Cambridge: Polity Press, 1986) p200-201.

external power but only a change in regulation.⁴⁸ But this is theorizing at such a level of intellectual abstraction that it appears to rule out *any* attempt to determine the relatively oppressive from the relatively liberatory (however historically contingent, partial and open to discussion these determinations will inevitably be). I return to this argument in detail in my final chapter.

⁴⁸ Nikolas Rose, 'Unreasonable Rights: Mental Illness and the Limits of the Law', p203.

Chapter Two: Emotions Shaped and Contained.

Mental Hygiene: Institutional Establishment and Altered Problematic.

Moral therapy, history and emotionality; these are the themes outlined in the prelude chapter. A moral therapy for the wider community then. But one that employed delineations of history as the basis of its authority to define, categorise, and control. And one that invoked history as a support to justify the separation of those whose 'will' could potentially be reasserted from those who were deemed to require the control of a constant and enduring external 'will'. In all this, however, the general problematic remained much the same as that of the older 'moral therapy'. The delineated field of the problem to be solved was the individual mind. A concept of 'social failure' was applied, both to the 'deserving' poor and mentally deficient people. And in both cases those who defined and cast these people, as problems to themselves and society, set the problem to be solved in terms of a failure of the 'will', of internal discipline. The deployment of this problematic served to diminish attention to other social and structural factors. In addition, where the former might be raised to responsible citizenship through the re-activation of the 'will' in their home environment, the latter required, it was claimed, a more permanent application of an external 'will' through direct supervision, segregation and discipline. The social reformers who claimed such expertise considered their own approach to be objective, reasoned, and civilized. Confident in their own reasonableness they sought to inculcate this into those displaying emotional indulgence and irrational excess. The

solution promised by their problematic excluded any response from those who were its object, other than in terms of an acceptance of the need for reform and emulation.

This chapter concentrates on the interwar period. This was the period in which mental hygiene became institutionally established. My focus remains, however, the nature and effects of the moral therapy problematic it employed. In fact with this establishment of the movement there took place a further revision. The formation of a general movement promoting a comprehensive mental hygiene for society as a whole became closely associated with psychoanalysis and, what was called, the 'new psychology'. Emotional irrationalities became construed as ubiquitous. The emotional content of mind was both conscious and unconscious. It now appeared that recalcitrant emotionality could not be simply subdued and controlled by the actualization of the objective 'will' and thus the regeneration of 'good character'. There was, in consequence, a shift in approach. It became required that emotionality should be understood and accommodated so that it might be shaped by the rational mind, rather than simply suppressed. I describe the alteration in this chapter and show that it had only marginal impact on people labeled mentally deficient.

There are two principal factors that I want to emphasize in this chapter. Firstly, despite now attempting to craft and shape emotions rather than subdue and neutralize them, mental hygiene remained a moral therapy. Secondly, an historical description of the nature of individuals, of society, and their past remained intrinsic to this extension of the psychiatric and psychological register. The shift in problematic entailed an altered rendition of history however. This was cast, of course, as revelation rather than construction. But what it amounted to was much the same as

had been promulgated by the social reformers discussed in the previous chapter: The past was given a countenance in order that individuals might have one. The responsible character of the progressive past was to imbue the character of individuals in the present. A rendition of history gave the past a character in the form of a vessel within which individuals in the present needed to fit. Whether one acknowledged it or not one's personhood was apparently imbued with the defining power of history.

The Mental Hygiene Movement

The mental hygiene movement in Britain is generally located as emerging during the interwar years.¹ I have located its emergence in the campaign for mental deficiency legislation from around the turn of the century. The interwar years were, however, clearly the period in which mental hygiene became institutionally consolidated as a movement.

Several clinics dedicated to psychotherapy for 'functional' nervous disorders were founded after the First World War. One of the most influential was the Tavistock Square Clinic founded by Hugh Crichton-Miller in 1920. Its creation has been seen as a milestone in regard to the growing acceptance of psychotherapy and psychoanalysis in Britain.² From the outset the Tavistock conceived its role in terms

¹ Nikolas Rose, for instance. See, *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939*, (London: Routledge & Kegan Paul, 1985), p158-164; Thomson, Mathew; *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870-1959*. (Oxford: Clarendon Press, 1998), p175-178, p272; Nick Crossley, 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health', *Sociology of Health and Illness* 20 4 1998 458-488.

² Roy Porter, 'Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain' in Hugh Freeman, German E Berrios, (eds) *150 Years of British Psychiatry Volume II: The Aftermath* (London: The Athlone Press Ltd, 1996), p391.

of preventing and treating mental troubles in the community through a strategy of mental hygiene.³ Along with three other interrelated organizations founded around this time the Tavistock formed the institutional nucleus of the mental hygiene movement.

Leading figures at the Tavistock Clinic were directly involved in promoting the formation of the National Council for Mental Hygiene (NCMH).⁴ This organization was founded in 1922 mainly by respected members of the Medico-Psychological Association. In the late 1920's it set up a Joint Committee with the Tavistock Clinic to further the aims of the mental hygiene movement.⁵ The Council's aim was to promote the development and use of the mental sciences.⁶ Its focus was on the optimisation of the mental health of the population at large through expert intervention to encourage 'normal' development. The Council's first president, Maurice Craig, maintained that the aims of mental science should be to provide counselling in the family and school, and better mental health facilities within society generally.⁷ In its first annual report the NCMH claimed that insanity was not the only manifestation of mental disorder, so too was crime and industrial inefficiency.⁸ Psychosomatic and emotional disturbance in the work place, it maintained could, however, be ameliorated through expert vocational selection.⁹ The NCMH was also strongly interested in international co-ordination of policies and movements for mental health, participating in two world congresses.¹⁰

³ Henry V. Dicks, *Fifty Years of the Tavistock Clinic* (London: Routledge & Kegan Paul, 1970), p1-4

⁴ Henry V. Dicks; *Fifty Years of the Tavistock Clinic*, p41, 42, 59, 84, 312.

⁵ Henry V. Dicks; *Fifty Years of the Tavistock Clinic*, p41-2.

⁶ Greta Jones; *Social Hygiene*, p82

⁷ Greta Jones; *Social Hygiene*, p82

⁸ Peter Miller and Nikolas Rose; 'The Tavistock Programme: The Government of Subjectivity and Social Life', *Sociology* 22 No. 2 May 1988 171-192, p177

⁹ Greta Jones; *Social Hygiene*, p70-71

¹⁰ NAMH *First Report 1946-7*, p5

The association of crime and 'social inefficiency' with mental pathology was central to the philosophy of a third organization, the Central Association for Mental Welfare (CAMW). The formation of this organization was a direct consequence of the institution of the 1913 Mental Deficiency Act.¹¹ Its membership was closely associated with the former NACF. The Board of Control, which had been set up under the Act, helped in the organization's formation and held a close association with it.¹² Under the Act local voluntary organisations could appoint themselves as experts in surveying the local population and assessing their mental competence. Those categorised as mentally defective and in need of institutionalisation were to be notified to the authorities for certification. The CAMW local committees carried out such tasks and also provided supervision for those defectives given leave from institutions on licence.¹³ By the interwar years the Association had expanded its activities and merged with other mental health groups to become the primary organisation concerned with mental deficiency. It now focused not only on creating and running mental health services through the recruitment and training of volunteers but also on providing conferences and courses for doctors, and training social workers.¹⁴

Both the CAMW and the NCMH were prominent in promoting another key organization of the mental hygiene movement. This was the Child Guidance Council,

¹¹ The organization began life in 1913 and was officially recognized by the Board of Control in 1914. It was originally known as the Central Association for the Care of the Mentally Defective. Due the expansion of its activity to adolescents and adults not certifiable under either the Mental Deficiency or Lunacy Acts, it changed its name to the Central Association for Mental Welfare. See, Aphra Hargrove, *Serving the Mentally Handicapped*, p23 and 31.

¹² Mathew Thomson, *The Problem of Mental Deficiency*, p153-155.

¹³ Greta Jones; *Social Hygiene*, p27

¹⁴ Greta Jones; *Social Hygiene*, p27

founded in 1927.¹⁵ Both the NCMH and the CAMW believed child guidance clinics to be central to providing comprehensive mental hygiene to the community.¹⁶ Ensuring mental adjustment during childhood was considered crucial to the prevention of later mental problems in adulthood. The NCMH concentrated on establishing child guidance clinics in Britain and training and recruiting psychiatric social workers to staff them. It saw this as part of its proselytizing role of encouraging the development of the mental sciences, and promoting better mental health facilities within society.¹⁷ Dame Evelyn Fox, the founder member of the CAMW, became the Child Guidance Council's first Honorary Secretary. This appointment exemplified the CAMW's extension of its remit both towards a wider professional integration and an extended consideration of the 'borderline' of mental health.¹⁸

The Ubiquity of Emotional Irrationality.

The emergence and interaction of these organizations was closely associated with the interwar impact of psychoanalysis. Psychoanalysis had made some inroads upon psychiatric and psychological thinking before the First World War. It had also had a certain impact upon the wider reading public. But its reception in Britain was uneven and controversial. In general, those British psychologists and medical men who were receptive to psychoanalysis gave it a qualified acceptance. Bernard Hart, and William

¹⁵ NAMH, *First Report 1946-7*, p5; Margaret A. Yelloly, *Social Work Theory and Psychoanalysis* (London: Van Nostrand Reinhold, 1980), p47-53.

¹⁶ See for instance, *Tenth Report of the National Council for Mental Hygiene 1932* (London: NCMH, 1933) p5.

¹⁷ NAMH *First Report 1946-7*, p5

¹⁸ Thomson; *The Problem of Mental Deficiency*, p164.

Brown, for instance, both took a keen, though critical, interest in Freud's work.¹⁹ The war, however, stimulated interest in what became known as the 'new psychology'. A concept of mental disorders as 'functional' rather than based on 'brain disorders' gained wide acceptance amongst doctors who treated 'shell-shock'.²⁰ The apparent need to analyse and understand unconscious motivations, coupled with the therapeutic value of 'talking therapies', became established as important areas for activity. Indeed professional interest in ideas of the unconscious and the psycho-neuroses became widespread. This extended to non-medical areas such as teaching and the prison system.²¹ In the 1920's A.F. Tredgold, the prominent psychiatric expert on mental deficiency and member of the CAMW, who was no advocate of psychoanalysis, lamented that, 'junior and inexperienced doctors' had seized upon it with 'avidity', as had educationalists and 'a large section of the general public and certain sections of the public press'.²²

Nevertheless, despite Tredgold's view, the concept of functional nerve disorders was of central influence to the mental hygiene movement. 'Functional nervous illness', wrote William Brown, was 'a disturbance in adaptation of personality to the physical, mental and social environment'.²³ The mental hygienist movement of the interwar period attributed these maladjustments to unconscious motivations; the emotional

¹⁹ See, for instance, William Brown, 'Freud's Theory of the Unconscious', *British Journal of Psychology* 6 (1914), 77-84; Bernard Hart, 'The Psychology of Freud and His School', *Journal of Mental Science* 56 (1910), 431-452. Also, Bernard Hart, *The Psychology of Insanity* (Cambridge: 1912).

²⁰ Martin Stone, 'Shell-Shock and the Psychologists', in W.F.Bynum, R.Porter and M. Shepherd (eds), *The Anatomy of Madness*, Vol. 2. (London: Tavistock, 1985). Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists 1914-1994* (London: Jonathan Cape, 2000).

²¹ Mark S. Micale argues that the First World War inaugurated the 'Age of Freud', although this seems truer in regard to the United States than Britain. See his, 'The Psychiatric Body', in Roger Cooter and John Pickstone (eds), *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic Publishers, 2000) 323-346, p331.

²² A.F. Tredgold, Review of, A. Wohlgemuth, *A Critical Examination of Psychoanalysis* (London: Allen & Unwin, 1924), in *Studies in Mental Inefficiency* 5 3 (1924), p67.

²³ William Brown, 'Rationalization', *Mental Hygiene* No. 6, December 1932, 34-37, p36.

substrates of the mind. The 'psycho-neuroses' were thus primarily disorders of the emotions.²⁴ Mental hygiene, as it developed during the interwar years, differed crucially from earlier moral therapy in how to deal with these emotional irrationalities. Psychoanalysis and the new psychology asserted the centrality of instinctual emotions to *all* behaviour and personality development.²⁵ Emotional irrationalities were present in everyone to varying degrees. These emotions could not be straightforwardly banished through the sustained application of 'reason' and the re-activation of the 'will'.²⁶ Maladjusted neurotic people could not simply respond to their own, or other people's, injunctions to 'pull themselves together'.²⁷ 'It is certainly necessary to have control', wrote one, 'but no one should live in a state of perennial self-control'.²⁸ Self-control should only be a temporary measure. Instead, of simply applying an external 'will' in order to re-activate it in the individual, mental hygienists emphasized their expertise in understanding the significance of emotions for both a mentally healthy individual and for society as a whole. As one put it, 'The will cannot control what it does not understand'. 'The note of the twentieth century', he continued, 'is awareness'.²⁹ Maladjustment of the personality was, thus, largely a matter of

²⁴ Maurice Craig, speech on, 'The Place of Mental Health in the Life of the Nation', given at Third Biennial Mental Health Conference 22nd to 25th November, 1933. Printed in, *Mental Hygiene* 8 January 1934, 8-10, p8.

²⁵ See, for instance, report of the Congree on Mental Hygiene, Washington 1930, *News Bulletin* (National Council for Mental Hygiene), July 1930, p12. Also, T.A. Ross, speech on, 'The Neurotic', given at Third Biennial Mental Health Conference 22nd to 25th November, 1933. Printed in, *Mental Hygiene* 10 July 1934, 86-90.

²⁶ This had ramifications for some mental hygienist's view of the Christian attitude to marriage. Hugh Crichton-Miller, Medical Director of the Tavistock Clinic, argued that only conduct and not feelings could be pledged on marriage. He used this insight, however, to demand that all the more emphasis should be placed on correct behaviour, with all marriage considerations based on 'posterity' and parenthood.; '...we should get away from this "froth and bubble" about companionate marriages', he argued. See, 'Conference on Mental Health', *British Medical Journal* 1 June 13th, 1931, p1030.

²⁷ J.R. Rees, 'The Neurotic', given at Third Biennial Mental Health Conference 22.11.1933. Printed in, *Mental Hygiene* 10 July 1934, 91-94, p92.

²⁸ Helen Boyle, 'The Prevention of Nervous Breakdown', *Mental Hygiene* no. 4 December, 1931, 9-14, p12.

²⁹ W. Langdon Brown, speech on, 'The Place of Mental Health in the Life of the Nation'. Given at Third Biennial Mental Health Conference 22.11.1933. Printed in, *Mental Hygiene* 8 January, 1934, 11-13, p12-13.

subconscious reactions and needed to be understood by 'exploration and explanation of the underlying causes.'³⁰ The claim was that rational thinking had finally grasped the fact that emotional experience underlay all growth and adjustment. Humans were dynamic organisms. Emotional experience was a necessary component of this. To understand and craft these emotions was claimed to be both rationally enlightened and more 'humane'. But, even so, this reconfigured attention to emotional experience was no more a straightforward 'kindness for kindness sake' than the earlier moral therapy. It was not a recognition that emotional and subjective experience was important in its own right. And it was not applied universally. Instead it was largely a means to an end. That end was adjustment to full, responsible and efficient citizenship, coupled to the continued progress of civilization.

Moral Therapy Extended: A Matter of Public Health.

Johannes Pols has recently written of how the interwar mental hygiene movement in the United States attempted to promote its agenda as a matter of public health:

Public health advocates had successfully conceptualized health as a requirement of citizenship. Mental hygienists added mental health as a similar requirement and, in addition, provided an explanation for the many infractions to the requirements of health and citizenship.³¹

³⁰ W. Langdon Brown, speech on, 'The Place of Mental Health in the Life of the Nation', p12; Hugh Crichton-Miller, 'Primitive Man and the Modern Patient', *British Medical Journal* 2 (1932), 430-432, p430-1.

³¹ Johannes C. Pols, *Managing the Mind: The Culture of American Mental hygiene, 1910-1950* PhD. Thesis, University of Pennsylvania, 1997, p184.

In Britain mental hygienists pursued the same aims. As we have seen, mental deficiency had been portrayed as a 'social problem' that represented a danger to societal health and should therefore be dealt with as a public health measure. Throughout the interwar years mental hygienists continued to describe mental deficiency in such terms. It remained closely associated with, 'criminality, dependency, vagrancy, prostitution, and allied social problems'.³² The Mental Deficiency Act had, however, only provided permissive legislation for local authorities to establish institutions. Of 60,000 ascertained defectives only 5,000 were in local authority institutions by 1927.³³ Both the CAMW and the NCMH pressed for greater institutional provision for mental defectives as a means of social and mental hygiene. The establishment appears to have accepted arguments for maintaining social control measures for defectives. The Geddes Committee, set up to reduce government expenditure during the onset of depression in the early 1920s recommended a raft of cuts including in education.³⁴ However, it did not attempt to reduce government contributions to local government under the Mental Deficiency Act because the Act was seen as 'essential to the physical and moral health of the nation'.³⁵

But, in addition to this continued agitation regarding mental deficiency, the new psychology, and the new discourse of emotionality that it heralded, now provided a far wider remit for a system of prevention and early treatment of mental disorders in

³² The Annual Reports of the National Council for Mental Hygiene throughout the 1920's and 30's make this clear. The quote is taken from the terms of reference of the National Council for Mental Hygiene's Sub-Committee on 'Mental Deficiency, Crime Etc.', *Ninth Report of the National Council for Mental Hygiene 1932* (London: NCMH, 1932), p21.

³³ Clive Unsworth, *The Politics of Mental Health Legislation*, p 173.

³⁴ T.O. Lloyd, *Empire, Welfare State, Europe: English History 1906-1992* (4th Ed) (Oxford: Oxford University Press, 1993), p113

³⁵ Clive Unsworth, *The Politics of Mental Health Legislation*, p174.

the community. Mental hygienists, pressed for an integrated system of public health on the basis of this. This was cast as a necessary extension and development of the 'social legislation' enshrined in the Mental Deficiency Act.³⁶

The appointment of a Royal Commission in 1924 (ironically partly prompted by concerns over wrongful detention in mental hospitals) provided an opportunity for advocates of mental hygiene to promote this vision. At the outset the prospects did not appear promising for the interests of psychiatry. Institutional psychiatry had made little breakthrough in the treatment of insanity.³⁷ Asylums continued to silt up with 'chronic' and apparently incurable cases. Added to this, the Royal Commission itself was predominantly made up of lawyers. But there were countervailing factors. Social intervention in the interests of public welfare and health had become increasingly influential. Notions of 'social medicine' and 'mental hygiene' were, in the process, gradually becoming acceptable and persuasive. As a consequence the objectives which informed the Commission were conceived as, public health, mental hygiene, national efficiency and social reconstruction.³⁸ Partly through these factors, mental hygienists, in fact, achieved a strong influence on the Commission.³⁹ Indeed, the Commission's outline of its 'General Considerations of Policy' followed closely the NCMH's evidence.⁴⁰ On the basis of this the Commission framed its

³⁶ In the early 1920s, for instance, Dr. C.H. Bond, in a Presidential address to the Medico-Psychological Association, outlined a scheme in which early signs of mental disorder would be quickly dealt with via a graded scheme including general practitioners, out-patient clinics, specialist in-patient clinics and finally the segregated mental hospital. See, C. Hubert Bond, 'The Position of Psychological Medicine in Medical and Allied Services', *Journal of Mental Science* 67 (1921), p404. Bond was medical Commissioner of the Board of Control, President of the MPA, and a member of the Executive Committee of the National Council for Mental Hygiene.

³⁷ The one success was in the diagnosis and treatment of General Paresis of the Insane.

³⁸ See Unsworth, Clive., *The Politics of Mental Health Legislation* (London: Clarendon Press, 1987), p112-118.

³⁹ Clive Unsworth, *The Politics of Mental Health Legislation*, p130.

⁴⁰ Moreover J.R. Lord, who was Secretary of the National Council for Mental Hygiene, gave evidence to the Commission on behalf of the M.P.A., and Sir Maurice Craig, the leading figure at the National

recommendations around the view that the treatment of mental disorder was a public health issue.⁴¹ This conceptualization entailed an acceptance that early detection and treatment of mental disorder was necessary. The keynote of the future', asserted the Commission, 'should be prevention and treatment'.⁴²

The Mental Treatment Act 1930 closely followed these recommendations. Clive Unsworth has made the important point that voluntary patient status, as conceived by the 1926 Commission, was not intended as a recognition of the freedom of patients to decide whether to enter or leave hospital in their own interests.⁴³ Rather, the voluntary status concept served to reduce the penal character of entry to mental hospital at the same time as it promoted a notion of social responsibility to submit to public health measures necessary to the interests of the community as a whole.⁴⁴ The hope was to encourage people suffering mental stress to submit to early treatment. This has relevance to strong constructionist accounts of the power of medicine and psychiatry that have placed this move to promoting voluntary treatment as an example of the beginnings of a turn away from custodialism. Like Unsworth they see this, less as a humanitarian impulse, than a psychiatric strategy that sought to capture mental distress before it became serious disorder. But they emphasize that through such means the psy disciplines could extend their remit, eschewing repressive and segregationist measures, in order ultimately to constitute a psychologized self via the

Council gave evidence as an individual. See Clive Unsworth, *The Politics of Mental Health Legislation*, p130.

⁴¹ *Report of the Royal Commission on Lunacy and Mental Disorder* (Cmd. 2700, 1926) para 43 and 50.

⁴² *Report of the Royal Commission on Lunacy and Mental Disorder*, para 42.

⁴³ Clive Unsworth, *The Politics of Mental Health Legislation*, p169-170.

⁴⁴ Doris Odum, 'The Meaning of the Mental Treatment Act, 1930', *Mental Hygiene Bulletin* no. 3 April 1931, 8-12, p11-12.

'voluntary enlistment of help from skilled technicians'.⁴⁵ However, the voluntary system that mental hygienists promoted cannot simply be associated with a move away from coercive aspects of psychiatry. The report of the Feversham Committee in 1936 makes this plain.

This Committee was formed by the Ministry of Health and charged with making proposals for the reorganisation of voluntary organisations so that they might 'increase their usefulness to the community'.⁴⁶ It had been requested by the NCMH and the Child Guidance Council. Its thirty-three members were mostly garnered from the leading mental hygiene organizations. The Committee was described at the time, and has been portrayed since, as an attempt to co-ordinate the diverse voluntary organizations working in mental health.⁴⁷ But more crucially the Feversham Report represented a further forceful commitment to founding a comprehensive regulation of mental health through a graduated system of clinics and institutions.⁴⁸ Its main conceptual proposition was that 'mental health' should be conceived and dealt with as a single concept incorporating, mental illness (whether organic or functional), mental deficiency, and delinquency. This was an assertion supported and promoted by the Board of Control. Its Annual report for 1935 stated:

The special problems of child guidance, of the treatment of borderline cases, of after-care and preventive care, and the manifold problems, medical, social and educational, associated with mental deficiency, are all closely related and

⁴⁵ Nikolas Rose, 'Law, rights and psychiatry', in Peter Miller and Nikolas Rose (eds) *The Power of Psychiatry* (Cambridge: Polity Press, 1986) p184-5 and p213. (Quote at p213).

⁴⁶ David and Irene Anderson; 'The Development of the Voluntary Movement in Mental Health' in MIND, *The Mental Health Year Book 1981/82* (London : MIND, 1982) 427-442, p431-2

⁴⁷ David and Irene Anderson; 'The Development of the Voluntary Movement in Mental Health', p431-2

⁴⁸ Feversham Committee, *The Voluntary Mental Health Services*, para 607.

to attempt to deal with them in isolation is neither scientific nor conducive to the most economical use of the available resources.⁴⁹

The Feversham report emphasized that this unity had already received partial legislative recognition under the 1930 Mental Treatment Act.⁵⁰ The Committee reiterated the 1926 Royal Commission's conceptualization of the treatment of mental disorder as a measure of public health. It contended that social legislation was generally accepted in the case of infectious diseases where 'protection of the community takes precedence over individual liberty'. Mental disorders, it argued, should be represented to the public in the same light. In order to assist this mental hospitals were to be established as places of treatment rather than detention, and afford 'every facility and encouragement for the ready acceptance of treatment by patients on a voluntary basis.'⁵¹

Uncommented upon by researchers, however, has been the fact that the Feversham Committee, also recommended that a system of voluntary provision without certification should be introduced for people categorized as mentally deficient.⁵² The Committee contended that the Mental Deficiency legislation should be brought into line with the procedures endorsed in the 1930 Mental Treatment Act. It complained that the 1913 Mental Deficiency Act had been based too much on the principles of the 1890 Lunacy Act and therefore 'governed by the fear of illegal detention.'⁵³ The Committee proposed that a system of voluntary provision should be established under

⁴⁹ *Report of the Board of Control for 1935* cited in, *Mental Health* 4 No.1 (1943), p3.

⁵⁰ Henry Herd, 'The Voluntary Mental Health Services: Report of the Feversham Committee', *Mental Welfare* 20 4 October, 1939 98-103.

⁵¹ Feversham Committee, *The Voluntary Mental Health Services*, para 45.

⁵² Feversham Committee, *The Voluntary Mental Health Services*, Recommendations, para xxviii.

⁵³ Feversham Committee, *The Voluntary Mental Health Services*, para 85.

which people deemed mentally defective would be admitted to institutions without the need for certification. Certification, it argued, 'should be reserved for cases where the consent of the parent or the patient cannot be obtained.'⁵⁴ What is important here is that, in the Committee's view, the circumstances under which a person categorized as mentally defective became 'subject to be dealt with' exemplified how 'too great an insistence on the liberty of the subject' defeated its own aims. It maintained that, under the regulations instituted by the Mental Deficiency Act, society only undertook its responsibility after such people had been neglected, cruelly treated, become criminals, or inebriates. It noted that the Radnor Commission, which had presaged the Act, had proposed that mental disability and not poverty or crime should be the criteria for state care and control. 'The principle which actuated the Commission', the Feversham Report emphasized, 'was that the community should assume control of defectives at an early age and continue that care as long as was necessary.'⁵⁵

This is not an image of 'voluntary provision' that sits easily with an apparent strategy that eschews control and coercion in order to sustain a more subtle regulation in the wider community. Moreover, mental hygiene attempted to unite mental deficiency, along with both serious and minor mental disorders, as part of an integrated whole. The key to appreciating this lies in the single most important term in the lexicon of interwar mental hygiene - 'adjustment'.

⁵⁴ Feversham Committee, *The Voluntary Mental Health Services*, Recommendations, para xxviii, and para89 and 361.

⁵⁵ Feversham Committee, *The Voluntary Mental Health Services*, para85.

The Multiple Uses of the Terminology of Adjustment.

The term 'adjustment' was pivotal in structuring mental hygienist's revised moral therapy for the community. Whilst the new psychology embodied the vanguard for mental hygienists' promotion of a modern 'rational therapy', the concept of adjustment performed a number of valuable unifying tasks.

The terminology of adjustment provided a conceptual link between the individual, society and history. British Idealist thinking had allowed a putative unification of these through the prior cause of an unfolding of 'reason' operating reciprocally through the twin operations of natural selection and the development of moral character. The concept of adjustment performed a similar task. In fact the terms adjustment and adaptation, along with other biological concepts of organism and function, had been applied to human psychology and social evolution since mid-nineteenth century.⁵⁶ Indeed, the terms 'adjustment' and 'maladjustment' had entered studies of child psychology from this time.⁵⁷ Intrinsically linked with these activities had been the notion of the progressive directionality of human and societal history. The concept of adjustment (or adaptation) was thus intimately associated with progressive societal change. Using the same terminology the new psychology, with its outline of emotional development as central to mental health and social efficiency could rest upon pre-existing descriptions of the past depicting it as a process of

⁵⁶ Robert M. Young, 'Herbert Spencer and "Inevitable" Progress' in, Gordon Marsden, *Victorian Values: Personalities and Perspectives in Nineteenth Century Society* (New York: Longman, 1990) 147-157; Robert M. Young, *Mind, Brain and Adaptations in the Nineteenth Century: Cerebral Localisation and its Biological Context from Gall to Ferrier* (Oxford: Clarendon Press, 1970); Roger Cooter, 'Phrenology and British Alienists', in Andrew T. Scull, *Mad-Houses, Mad-Doctors and Madmen* (London: Athlone Press, 1981) 58-104.

⁵⁷ Gertrude Keir, 'A History of Child Guidance', *British Journal of Educational Psychology*, 1952, 22, 5-29, p6.

developmental stages of the human mind and society. This was given expression in the description of mental hygiene as having two divisions; positive, to ensure healthy mental development and social adjustment; and negative, to prevent and cure mental deterioration.⁵⁸ The new description of the history of emotional development fell under the former division. Mental deficiency fell under the latter. And, as we shall see, mental hygienists' attention to emotional experience differed sharply between the two.

The Feversham Committee insisted that 'mental health' was a unitary concept to be understood in terms of 'adjustment' and 'maladjustment'. And as such all maladjustments, whether mental defects, mental disorders, organic, functional, or expressed as delinquency, represented 'departures from a normal condition of mental health.'⁵⁹ One prominent mental hygienist described the widened mental hygiene remit in this fashion:

Whereas in the old days we fondly hoped that the solution of the problem of the unfit, the degenerate and the social misfit, would be found in the proper control of defectives, we have now discovered that the mental defective forms but a small percentage of that great army of failures of civilization which is found in every country in the world. The sub-normal, the unstable, the unbalanced, the temperamentally defective, the victim of certain forms of physical illness, of bad inheritance and environment ... all these make a call on us as human beings, not only by reason of their own misery and of the

⁵⁸ 'National Council for mental Hygiene', *British Medical Journal*, March 29th, 1930, p608. See also the mental hygienist Kenneth Soddy's similar description written some two decades later; Kenneth Soddy, 'Mental Health', *International Health Bulletin of the League of Red Cross Societies*, 7 No.2, April-June, 1950, 8-13.

⁵⁹ Henry Herd, 'The Voluntary Mental Health Services', p99.

sorrow they cause to their family and friends, but from their inability to take their place as citizens They fail to recognise, or they are incapable of recognising, the accepted standards of the community in which they live and of which they form a part.⁶⁰

The terminology of adjustment also provided a conceptual umbrella under which diverse and antagonistic specialisms in medicine, psychology and sociology could operate in terms of an apparently single spectrum that encompassed 'deteriorated schizophrenics' and 'gross idiots' at one end, and 'psychoneurotics' and 'delinquents' at the other. As J.R. Lord put it, 'there is no question of mental disease ever being cured from a single standpoint'. Instead, he stressed the 'mosaic' nature of mental hygiene where a number of different approaches, including eugenic sterilisation, could and should be employed to deal with mental disorders.⁶¹ A range of approaches, from psychotherapy through to physical treatments, could putatively be encompassed under this general requirement to promote individual adjustment to the social organism and to prevent and treat maladjustment. As a consequence mental hygienists, although they were never comfortable with them, could partially accommodate ideas based on the physiologist Ivan Pavlov's 'behaviourist' theory, now known as Classical conditioning.⁶² Likewise, the 'heroic' physical treatments developed between the wars

⁶⁰ Rt Hon. Sir Lesley Scott, Chairman's introduction to discussion on, 'The Proper Care of Defectives Outside Institutions' in, Central Association for Mental Welfare, *Report of a Conference on Mental Welfare Held in the Central Hall, Westminster, London, SW on Thursday and Friday, December the 2nd and 3rd, 1926* (London: CAMW, 1926) 17-23, p21-22.

⁶¹ F E Williams (MD), (ed) *Proceedings of the First International Congress on Mental Hygiene : Held at Washington DC, USA May 5th to 10th, 1930* (Two volumes) (International Committee for Mental Hygiene Inc., 1932), p495.

⁶² Thus some mental hygienists made limited use of his work. See for instance, J.R. Rees, *The Health of The Mind* (London: Faber & Faber, 1929), p44-46; E.M. Creak, 'Sleep disorders in Childhood' in, R.G. Gordon, *A Survey of Child Psychiatry*, (London: Oxford University Press, 1939) 222-234, p222; A. Helen Boyle, 'Family Life: Some Difficulties and Dangers', *Mental Hygiene* No13. April 1935 47-53, p47. The first psychologist to apply Pavlov's work to humans was the American John Watson, who was also influential in Britain. He employed the notion of 'habit training' in conjunction with the

could be grounded in the same conceptual frame. By the early 1930's Pavlov had, in fact, coined the term 'experimental neurosis' to describe dogs' apparently 'neurotic' responses – trembling, whining, urinating, refusing to eat – induced by deliberate manipulation of stimuli to create confusion.⁶³ This suggested the direct application of his model to the area of psychopathology. Thus, abnormal human behaviour might be adjusted, it seemed, in the laboratory. And, in fact, from the mid-1930's the development of the surgical operation of lobotomy (also known as leucotomy) grounded its scientific justification on the model of 'experimental neurosis' and the associated concept of adjustment to the social environment.⁶⁴

In addition to these uses, the notion of adjustment accorded with the expressed mental hygiene strategy of extending the psychiatric sphere of influence outside of the asylum. It enabled a fusion of 'right living' with responsible adaptation to society. 'Right living' could now become a matter of mental health. Psychiatric and psychological experts placed themselves as uniquely geared to mediate mental adjustment and good citizenship.⁶⁵ Psychiatrists who might look in despair at the proliferation of serious mental disorders as exemplified in overcrowded mental hospitals could, instead, turn with a clearer conscience to teaching the general public how better to avoid such calamities. In contrast to the conditions in mental institutions, psychiatrists promoting mental hygiene were able to disavow any

requirement for correct adjustment to society. His harsh measures were, however, not in keeping with mental hygienists conceptualization of 'normal' and 'maladjusted' children's emotional 'needs'.

⁶³ Richard D. Gross, *Psychology: The Science of Mind and Behaviour* (2nd ed.) (London: Hodder and Stoughton, 1992), p169.

⁶⁴ Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), chapter one.

⁶⁵ For example, Hugh Crichton Miller, 'Nature and Nurture in Mental Hygiene', *Eugenic Review* 33 1941-1942 121-124; Hugh Crichton-Miller, *The New Psychology and the Parent* (London: Jarrolds, 1922); Morris Ginsberg, C.G. Seligman, Ramsay Muir (et al), *Psychology and Modern Problems* (London: University of London, 1935).

connection with the minor mental troubles they highlighted in the community. As one leading exponent put it:

Fortunately we need not hold ourselves responsible for the woeful prevalence of mental disability that is usually disguised by the term "nerves". These minor mental maladies are mainly attributable to dysgenic propagation, to economic insecurity, to parental stupidity, to unhelpful religious influences, to faulty education, or to sexual difficulties.⁶⁶

But, as the above quote displays, mental hygienists' attention to what they considered evidence of mental maladjustment to society, was riven with social and moral prejudices. They constantly invoked a definition of maladjustment in terms of deviation from social 'norms'. Moreover, these norms were most often an ambivalent conflation of norms constructed through statistical measurement (such as mental tests) and norms simply asserted by reference to the 'interests' of the 'community as a whole'. Mental hygienists, in effect, claimed to be the arbiters of the psychological 'interests of the community'. And, they implied that upon this 'health' rested everything else. The social ills of the 'backward' child, the persistent thief, the sex offender, the acute depressive and the 'unmanageable rebel' were, as one mental hygienist put it, not different problems but, 'in reality a single one, that of helping the sufferer to a better adjustment of life, in short, of restoring to him mental health'.⁶⁷

⁶⁶ Hugh Crichton-Miller, 'Psychotherapeutic Clinics in Fact and Fancy', *British Medical Journal* June 15th, 1935, 1205-1208, p1205.

⁶⁷ W.J.T. Kimber, cited in *Mental Welfare*, 20 4 (1939), p103.

'Man' Without a History is a Threat to the Moral Order

Descriptions of how psychiatric knowledge has extended its influence out from the asylum and into the wider community have become commonplace. The generally accepted image is one of an ever widening 'psychologization' of society. The movement for mental hygiene is acknowledged as an important strategy associated with this process. But a historiography often fully preoccupied with establishing the extent and power of this growing 'psychologization' of society in the twentieth-century greatly ignores the way in which the past has been ordered and structured as a part of this process.⁶⁸ History has been deployed as part of the means to define the essentials of personhood, its mental health and deviations. This omission is particularly notable in the strong constructionist descriptions of this process, provided by David Armstrong and Nikolas Rose.⁶⁹ For them this process of 'psychologization' does not simply represent, as it does for some other writers, a professional power that has extended its influence and at the same time provided a vocabulary that imbues our descriptions of ourselves. Rose and Armstrong maintain that this twentieth-century process is instead a part of a longer historical process that has constituted an actual interiorization of personhood. They are not alone. Many writers have argued that our

⁶⁸ For instance, Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (London: Harvard University Press, 1999), Harry Hendrick Harry, *Child Welfare: England 1872-1989* (London: Routledge, 1994) ; Johannes C. Pols, *Managing the Mind: The Culture of American Mental hygiene, 1910-1950*; Cathy Urwin and Elaine Sharland, 'From Bodies to Minds in Childcare Literature : Advice to Parents in Interwar Britain', in Roger Cooter (ed); *In The Name of The Child* (London : Routledge, 1986) 174-199.

⁶⁹ David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983); David Armstrong, *A New history of Identity: A Sociology of Medical Knowledge* (Basingstoke: Palgrave, 2002); Nikolas Rose, *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939* (London: Routledge and Kegan Paul, 1985); Nikolas Rose, 'Unreasonable Rights: mental illness and the limits of the law', *Journal of Law and Society*, 12 (1985), 199-219. (Reprinted and extended as 'Law, Rights and Psychiatry' in Peter Miller and Nikolas Rose (eds), *The Power of Psychiatry* (Cambridge: Polity Press, 1986), 177-213); Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Routledge, 1989); Nikolas Rose, *Inventing Our Selves: Psychology, Power and Personhood* (Cambridge: Cambridge University Press, 1998).

experience of ourselves as psychologically interiorized and self-reflexive is historically contingent and not a universal fact. Theodore Adorno, in his critique of Soren Kierkegaard's philosophy argued that subjective interiority is an historical manifestation of the commodity forms of bourgeois reality.⁷⁰ Norbert Elias traced the psychoanalytic dynamics of superego, repression and neurosis, to 'the civilizing process'; by which he meant the development of middle and upper class moral and social codes, of social regulation.⁷¹

But mental hygienists also contended that the interiorized individual was the modern result of historical processes. Their particular ordering of the past asserted its progressive character. We have seen how the moral therapy problematic was deployed in society by social reformers using history as an authoritative support. Mental hygienists continued this manoeuvre. They purveyed an image of personhood that was intrinsically and indissolubly historical in nature. According to them each person bore the imprint of the past in the progressive development of their mind. Just as the past was presented as a series of stages in the progression of the mind from 'primitive' to 'civilized', so each individual was presented as recapitulating this development in their own growth. But, employing the new psychology, mental hygienists described this progress in terms of emotionality as well as intellect. According to mental hygienists, in 'primitive' society individual emotionality was dealt with by quickly bringing it under communal control and convention. In modern society, however, each individual mind needed to control and integrate these feelings

⁷⁰ Theodore Adorno, *Kierkegaard: Construction of an Aesthetic* (Minneapolis: University of Minnesota, 1989).

⁷¹ Norbert Elias, *The Civilizing Process*: vol. 1, *The History of Manners* ((Oxford: Basil Blackwell, 1978).

themselves.⁷² Thus, each person passed through stages of emotional, as well as intellectual, development. Mental hygienists therefore described an historical process of individualization.⁷³ It was claimed that, in 'primitive' societies, the 'group control and conventionalization' that took place from an early age stultified individuality and freedom.⁷⁴ By contrast, in 'civilized' society the individual 'mind' had superseded the group 'mind'. Individual intellect now controlled and rationalized instincts and emotions. But reason had not simply supplanted instinctual and emotional feelings. The latter remained principal factors in personhood. The 'primitive' resided inside everyone. As Emanuel Miller, a leading figure in child guidance, put it:

... while the looser texture of civilized society has allowed for individuality, it has also submerged those bonds which, at one time visible in group conventions, were strong enough to break the individual. If at one time the individual was moored by a visible rope to the social quayside, he is now anchored to the sea-bed by cables which, though hidden, are no less strong and binding.⁷⁵

But mental hygienists did not seek to promote a society of individualists.⁷⁶ On the contrary. They feared that, though individual and intellectual freedom had, in their view, inaugurated the rise of civilization, they had also brought with them problems that inhibited the necessary adaptation of individuals to modern society. Just as British Idealist thinking contended a reciprocal relation between individual and

⁷² Emanuel Miller, *The Generations: A Study of the Cycle of Parents and Children* (London: Faber and Faber, 1938), p35.

⁷³ Emanuel Miller, *The Generations*, p37-42; William Brown, 'Character and Personality', *Mental Hygiene* No.13 April, 1935 54-56, p54.

⁷⁴ Emanuel Miller, *The Generations*, p35-36.

⁷⁵ Emanuel Miller, *The Generations*, p36.

⁷⁶ J. R. Rees, *The Health of The Mind* (London: Faber & Faber, 1929), p215.

society, mental hygienists also understood an individual to develop the moral nature of their mind through interaction with, and adaptation to, the community.⁷⁷ As Cyril Burt, the influential psychologist associated with the mental hygiene movement, put it: 'There are no Robinson Crusoes.' Similarly, mental hygienists posited a relationship between the individual and the state that had imbued the thought of British Idealist thinkers such as those influential in the Charity Organization Society. Neither the individual nor the state could exist without the other. Each existed in a reciprocal relation of rights and duties.⁷⁸ For mental hygienists, primitive emotionality resided in individual minds and mediated their engagement with society. An appreciation of this historical nature of personhood was a necessity, therefore, in order to hold together the social and moral order.⁷⁹

To mental hygienists, unawareness of the historical nature of personhood and its reciprocal relation with society was dangerous. It was dangerous because to be unaware of the 'immature', 'primitive' aspects in one's thinking and reactions, was to be vulnerable to other retarding 'primitive' forces at large in the social order. But it was also dangerous because one's own unrestrained emotionality promoted such degenerative social forces.

Mental hygienists' conceptions of mental health and disorder were informed by this view. Their descriptions of childhood emotional maladjustment and of mental deficiency reveal this. Since it was principally through childhood that individuals

⁷⁷ Emanuel Miller, *The Generations*; Hugh Crichton-Miller, *The New Psychology and the Parent* (London: Jarrolds, 1922).

⁷⁸ For a concise exposition of this see, Cyril Burt, 'The Psychology of Politics' in, Cyril Burt (ed.) *How the Mind Works* (London: George Allen and Unwin Ltd, 1933) [second edition 1948] 225-245 (Quote at p 230).

⁷⁹ Emanuel Miller, *The Generations*, p179; Cyril Burt, 'The Psychology of Politics', 225-245.

were regarded as recapitulating the posited stages of development, mental hygienists paid particular attention to promoting children's healthy 'adjustment'. Correct child development, for mental hygienists, was essentially a process of the creation of a moral self adjusted to the necessities of the social order.⁸⁰ As one prominent mental hygienist put it:

[Child psychology] ... embraces not only the mental accompaniments of certain diseases, formerly studied mainly from an organic point of view, but also those disorders of personality, sociological maladjustments, and behaviour difficulties hitherto regarded as transgressions of the moral and social code rather than illnesses which concern the medical profession.⁸¹

In the first few years of life, wrote the psychoanalyst Ernest Jones, the child effectively condensed 'a hundred thousand years of mental evolution' as it endeavoured to adapt itself to 'civilized standards'.⁸² But mental hygienists contended that, for adults, a personal appreciation of the details of this recapitulation was obscured as if by a mist through the obligations and interests of later years.⁸³ Mental hygienists claimed to reveal these processes. They combined a description of instinctual 'needs' with an elaboration of how these were moulded by experiential stages of development. Building on long existing notions of the child's mind as

⁸⁰ Emanuel Miller, 'How the Mind Works in the Child' in, Cyril Burt, Ernest Jones, Emanuel Miller and William Moodie, *How the Mind Works* (London: George Allen and Unwin Ltd, 1933) [2nd edition, 1945] 107-178, p141.

⁸¹ D.R. MacCalman, 'The General Management of Maladjustment in Children' in, R.G. Gordon, *A Survey of Child Psychiatry*, (London: Oxford University Press, 1939) 257-268, p257.

⁸² Ernest Jones, 'The Unconscious Mind' in, Cyril Burt, Ernest Jones, Emanuel Miller and William Moodie, *How the Mind Works* (London: George Allen and Unwin Ltd, 1933) [2nd edition, 1945] 61-103, p84.

⁸³ Emanuel Miller, 'How the Mind Works in the Child', p109.

'plastic'⁸⁴ and malleable, 'habit training' was re-cast in terms of the understanding of instinctual and emotional 'needs', and the application of rational management based on this understanding. This was a vision that considered minor maladjustments to be common and relatively easily treatable. Persistent maladjustments, however, required expert categorization and treatment.⁸⁵ These latter cases had not developed fully through the stages of widening social and moral responsibility. They remained at earlier phases concerned less with social responsibility than with immediate experience. They had not developed with the grain of human history and so their personal history was truncated, their perspective on life distorted and their experience more closely limited to that of their own immediate senses.

It is here that the discourse of emotionality superimposed as it was upon extant histories of individual and societal evolution was integrated with prevailing depictions of mental deficiency. People diagnosed under the latter category were, by definition, deemed to lack the intellectual capacity needed for the 'self-knowledge' offered by the new psychology. In similar, though more radical fashion, their histories were also truncated, and thus so was their social responsibility and efficiency. They too were locked in a present centered world. For them, however, this was deemed largely irreversible. Thus a system of care and control was required that embodied the social awareness and discipline which they lacked.

Mental hygiene, then, conjoined an historical and psychological register in its attempt to mediate a functional fit of individual and society. Either to be unaware of this history, or to represent an arrestment or deviation from it, constituted a danger, both

⁸⁴ Emanuel Miller, 'Psychiatry of Children' in, Sir Humphrey Rolleston (ed) *The British Encyclopaedia of Medical Practice* (London: Butterworth & Co., 1938) 203-212, p210.

⁸⁵ D.R. MacCalman, 'The General Management of Maladjustment in Children', p265.

to oneself and society. To be such was to be dominated by the temporally immediate and environmentally proximate. One's feelings and behaviour were located in the present, apparently unmediated by the moral structure of history.

A new dispensation: the ordering of society by the ordering of minds.

The crux of the mental hygiene approach rested on the assertion that rational thinking had finally grasped the fact that emotional experience underlay all growth and adjustment. The ability to understand how emotional experience was a necessary component of this development was conceived as both rationally enlightened and more 'humane'. Such a rational approach was considered, by definition, to combine the potential for greater human happiness and greater societal efficiency. It followed from this that the greater a person's intellectual capacity the more their potential ability to understand and regulate their emotionality in the interests of their own development and that of society. A healthy personality was quintessentially about the understanding and thus management of the emotions by the rational mind. If the new psychology had shown that the 'primitive' and the 'archaic' remained intrinsic aspects of 'civilized man' in the form of emotionality and irrationality, it was nevertheless asserted that those with greater ability to reason had the most potential for insight and ascendance.⁸⁶ This mental management was likened, by some, to the captaincy of a

⁸⁶ Hugh Crichton-Miller, 'Psychotherapeutic Clinics in Fact and Fancy', *British Medical Journal* June 15th, 1935, p1206; Hugh Crichton-Miller, 'Primitive Man and the Modern Patient', *British Medical Journal* 2 (1932), 430-432, p430-1; J. Campbell McClure, 'Psychology and the Practice of Medicine', *British Medical Journal* 1 29th March, 1931 609-611, p609.

well-ordered ship and crew.⁸⁷ The aim was that a person should 'learn how to govern his instincts so as to avoid conflict in his own mind and conflict with his neighbours.'⁸⁸ Or as the influential psychiatrist J R Lord grandly characterized it, mental hygiene represented 'the dominance of reason over emotion in the moulding of personality in such a fashion as to bring out the finest traits of human character'.⁸⁹ Thus, if emotionality was privileged under the psychotherapeutic imperative of the interwar mental hygiene movement, intellectual capacity was to be the common denominator. Moreover, the image of a graded hierarchy of function and fit, suggested by the metaphor of the captaincy of a ship and its crew, was reflected in mental hygienists' aspirations to link individual and societal 'health'.

The attribution to mental hygiene of an ability to teach 'man' how to 'live at peace with himself and society' suggested grandiose schemes of social reform.⁹⁰ And indeed, mental hygienists consciously embraced such visions. Maurice Craig, the president of the National Council for Mental Hygiene, put it in characteristically functionalist terms: 'A nation is composed of units, and the harmonious working together of these units leads to a greater stability and happiness, and both of these are the special care of the National Council for Mental Hygiene.'⁹¹ Mental hygienists confidently espoused a self-professed expertise in virtually every social institution. Childhood upbringing, education, occupational guidance, industrial efficiency, delinquency, crime; all of these became targets for this extension of moral therapy outwards to the community. J R Lord, speaking at the Second Biennial Conference

⁸⁷ J. R. Rees, *The Health of The Mind* (London: Faber & Faber, 1929), p19-20; T.A. Ross, 'The Neurotic', *Mental Hygiene* No.10 July 1934, 86-90, p87-88.

⁸⁸ Letitia Fairfield, 'Crime and Punishment', *Mental Hygiene* No.4 December, 1931, 17-20, p18.

⁸⁹ Cited in National Council for Mental Hygiene, *News Bulletin* July 1930, p13.

⁹⁰ Letitia Fairfield, 'Crime and Punishment', p18.

⁹¹ Maurice Craig, 'Mental Hygiene in Everyday Life', *Mental Hygiene* no.7 July, 1933, 57-64, p63.

on Mental Health held in London in 1931 forthrightly propounded this all-encompassing 'expertise'. In his speech he declared:

Mental hygiene must direct its efforts in all nations to deal effectively with the emotionally unbalanced or criminally disposed section of the public.... Many of these are mental defectives, morons and the like, who should be under constant institutional care Improved methods of school teaching, child guidance and parental education, the encouragement of trained workers in every field of social and economic activity, are all measures of sound prophylaxis, and would rid future generations of many such dangerous elements.

... It is imperative, too, that instruction in mental hygiene should be compulsory in all colleges and universities, from which the ruling classes are largely drawn.

... Nations must see to it, and provide machinery for the removal of all monarchs, rulers and governors who are mentally and morally unfit for their high duties and great responsibilities. Princes in the line of succession in monarchical countries should have psychiatrists and psychologists among their medical advisors. ...

Equally important in democratic countries is the mental health of high officers of state, and especially those occupying executive positions; nor can such education be neglected by lesser legislators and administrators.⁹²

⁹² Thomas Röder, Volker Kubillus, Anthony Burwell, *Psychiatrists - The Men Behind Hitler* (Los Angeles: Freedom Publishing, 1995), p261. On the conference see also the report in the British Medical Journal, 'Conference on Mental Health', *British Medical Journal* 1 13th June, 1931, p1030.

The rapid development of mental testing between the wars provided mental hygienists with an apparently scientific and objective means to differentiate between the kinds of people categorized in Lord's speech. Here again the concept of individual adjustment to the environment proved valuable for the programme of mental hygiene. Despite claiming to determine some essential and cardinal faculty of mind, mental testing was in fact, by the interwar years, self-consciously promoted as a means to measure adjustment to social and educational demands.⁹³ For mental hygienists these tests provided a spectrum upon which a range of stages of development and putative deviations from them could rest. But, at the same time, they enabled the retention of a relatively straightforward bifurcation between people deemed 'mentally arrested' and thus a constitutional threat to societal progress on the one hand, and the rest of the population on the other.

The historian Mathew Thomson's detailed analysis of mental deficiency policy between the wars has situated it firmly within the wider political context of 'adjusting to democracy'.⁹⁴ At the same time Thomson has emphasized that the impact of democratisation and social citizenship was mediated by status.⁹⁵ Mental deficiency provided a new boundary to define citizenship. In my view mental hygienists envisioned mental tests as a putatively objective means to distribute status in what they hoped would be a new 'meritocratic' order. And this manouvre itself rested upon an historical conceptualization of the progressive development of 'minds' and societies. The hierarchy of race and in-born class was now to be replaced with

⁹³ Nikolas Rose, *The Psychological Complex: Psychology*, p127-131.

⁹⁴ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870-1959*. (Oxford: Clarendon Press, 1989); Mathew Thomson, 'Constituting Citizenship' in, Chris Lawrence and Anna K. Mayer (eds) *Regenerating England: Science, Medicine and Culture in Inter-War Britain* (Amsterdam: Clio Medica, 2000).

⁹⁵ Thomson; *The Problem of Mental Deficiency*, p293

another hierarchy, the hierarchy of intellect. A hierarchy of history was, on this account, reflected in a hierarchy of mind, which in turn was reflected in a hierarchy of the social order.

Social reformers had quickly latched onto intelligence tests when they were developed just before the First World War. Early mental tests were assumed to measure a fixed and innate intellectual capacity.⁹⁶ One of their first uses had been as an apparently 'scientific' measurement of mind that could inform the diagnosis of mental deficiency in those cases they considered 'feble-minded'.⁹⁷ It has been noted, in recent years, that despite purportedly placing 'backward' and mentally deficient people on the same continuum as other people, with differences cast in terms of degree, mental tests in fact served to separate and segregate mentally deficient people.⁹⁸ But the term 'continuum' used here is something of a misnomer. The idea of a continuum suggests a series that makes up part of a whole and in which no part is perceptibly different from adjacent parts. These mental tests, however, constituted an apparently scientific method of separation into stages of mental development analogous to the racial and societal hierarchies of Victorian anthropologists. Just as much as constructions of racial and cultural hierarchies they represented a means to categorize, rank and separate. Their *function* was to make more refined disjunctions.⁹⁹ It is therefore not surprising that they provided a means to define an

⁹⁶ Alfred Binet and T. Simon, *Mentally Defective Children*, (London: Edward Arnold, 1914)

⁹⁷ See S. Sharp and Gillian Sutherland, 'The First Official Psychologist in the World', *History of Science* 18 (1980), p181-208.

⁹⁸ Joanna Ryan and Frank Thomas, *The Politics of Mental Handicap*, p111.

⁹⁹ Contrast, for example, the description of the 'normal distribution curve' of intellectual capacity given by R.G. Gordon (Medical Director of the Child Guidance Council) with his differentiation between, feeble-mindedness, and backwardness, of which the former, it was maintained, were not suitable for child guidance work; R.G. Gordon, 'The Medical Aspects of Backwardness', in, R.G. Gordon, *A Survey of Child Psychiatry*, (London: Oxford University Press, 1939), 137-151, p137.

apparently firm line between the 'normal' and 'subnormal' at the same time as they enabled finer gradations of the capacities of 'minds'.¹⁰⁰

These, then, were measures of a person's capability for adjustment, and mental hygienists were able to use them as a means to rank the 'minds' of people in terms of a 'healthy' functional fit for society. As the influential psychologist Cyril Burt put it:

The state, in fact, must erect a double ladder – a ladder whereby the intelligent can climb up to their proper place, while the less intelligent, from whatever sphere, drop down to their own true level. In this way, while the nation helps the individual, the individual will help the nation.¹⁰¹

An impression of how measurements of intelligence informed the classification and distribution of minds in terms of a mental hygiene of society can be gleaned from the following table (taken from a work by Cyril Burt) supplied by the psychiatrist R.D. Gillespie in his discussion of 'mental hygiene as a national problem'.¹⁰² He introduced

¹⁰⁰In fact, this line of demarcation proved distinctly mobile. The 1929 Wood Committee on mental deficiency determined an *upper* IQ borderline for the diagnosis of adult feeble-minded people at around 57%. But the 1954 Royal Commission on Mental Illness and Mental Deficiency determined that people measured *below* an IQ of 50–60% should be considered *severely* sub-normal. The National Council for Civil Liberties drew attention to this apparent extension of the mental deficiency system's remit in its response to the 1959 Royal Commission. See, NCCL, 'The Next Steps: The Submissions of the National Council for Civil Liberties to the Minister of Health on the Recommendations of The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-7', paras 48-50 (NCCL, Hull Archives DCL86.3).

¹⁰¹Cyril Burt, 'The Psychology of Politics' in, Cyril Burt (ed.) *How the Mind Works* (London: George Allen and Unwin Ltd, 1933) [second edition 1948], p245.

¹⁰²R.D. Gillespie, 'Mental Hygiene as a National Problem', *Mental Hygiene* No. 4 December 1931, 1-9, p5.

it as showing 'the influence of intellectual level on economic efficiency':

<i>Vocational Category</i>	<i>Prop. Of total pop.%</i>	<i>IQ %</i>
1. Higher Professional	0.1	165%
2. Lower Professional	1 per 1000	140%
	3 " "	
3. Higher business positions and highly skilled workmen.	12	125%
4. Skilled workmen. Most commercial positions.	27	110%
5. Semi-skilled workmen. Poorer commercial positions	36	95%
6. Unskilled labour etc.	19	80%
7. Casual labour (feeble-minded)	3	70%
8. Defective adults in institutions (imbeciles and idiots)	0.2	50%

It is unclear to me whether 'economic efficiency' was intended, here, to refer to personal economic remuneration or to some contribution to the economic efficiency of society – or both. Nevertheless, this hierarchy of employment categories represents an implied hierarchy of 'worth'. And this is compounded by the explicit elision (at the 'lowest' levels) of employment classifications with medical categories of incomplete or arrested development of mind. This table presumably represented, not only, present reality as Burt and Gillespie saw it, but also a frame of reference that informed their proposals for vocational training to avoid the problem of the 'misfit' in society. This functionalist vision wasn't without its contradictions however. As a speaker at a CAMW conference in 1926 put it, if mental hygienists were to eliminate

the problem of 'sub-normals', 'the problem of domestic service, for example, would become even more acute than it is.'¹⁰³

Mental hygiene, then, was thoroughly imbued with a hierarchical model of mind that mirrored a particular vision of the social order. In the 1990's the historian Roy Porter remarked that:

It is open to real dispute how far the science of psychiatry as a whole is 'objective knowledge', or how far it rather constitutes an objectification of social values. Notions of the hierarchical structure of the mind ... seem suspiciously to mirror traditional concepts of the social hierarchy ...¹⁰⁴

We have already seen the way in which the 'nature' of personhood was presented as indissolubly historical. The hierarchy of mind described by mental hygienists was presented as, both a product and a motive force of the progressive past. This particular classification and interpretation of the past was invoked as an authority in the moral definition of personhood. In the citation above Roy Porter was arguing for the importance of academic historical explanation in revealing the complicity of psychiatric knowledge with the social and political ordering of society. However authoritative descriptions of the past as history are not so easily separated from the processes some might wish to illumine. The historical register is inextricably entangled in such issues. But, more than this, the notion of a graded social hierarchy based on the putative intellectual capacity of individual minds, promoted by mental

¹⁰³ W.R.K. Watson, 'Some Observations on Borderland Cases and Delinquency', CAMW, *Report of a Conference on Mental welfare Held at the Central Hall, Westminster, London, S.W. on Thursday and Friday, December 2nd and 3rd, 1926* (London: CAMW, 1926), p80.

¹⁰⁴ Roy Porter, 'Madness and its Institutions' in, Andrew Wear (ed) *Medicine in Society* (Cambridge: Cambridge University Press, 1992)277-301, p300.

hygienists, remains a quintessential aspect of the academic environment. It is a social order that is itself founded upon a purported hierarchy of minds. Given such extant and pervasive factors, it is perhaps not surprising that some contemporary historians can express views similar to Cyril Burt's on the 'contents of heads'. Marvin Perry, for instance provides a particularly forthright example. In a work used as a standard text on at least one undergraduate history course, he informs his readers that 'history has shown' that fears about mass democracy prevalent amongst nineteenth century liberals were not unfounded:

In the twentieth century, the participation of common people in politics has indeed threatened freedom. Impatient with parliamentary procedures and seduced by appeals to passions and prejudices, the masses, particularly when troubled by economic problems, have in some instances turned their support to demagogues who promised swift and decisive action. The granting of political participation to the masses has not always made people freer. The confidence of democrats has been shaken in the twentieth century by the seeming willingness of common people to trade freedom for authority, order, economic security, and national power. Liberalism is based on the assumption that human beings can and do respond to rational argument, and that reason will prevail over base feelings. The history of our century [the twentieth] shows that this may be an overly optimistic assessment of human nature.¹⁰⁵

Does it? Note the elision of 'common people' with 'human nature' here. Perry is being disingenuous. 'Human nature' is a universal after all and he has already made it

¹⁰⁵ Marvin Perry, *An Intellectual History of Modern Europe*, (Boston: Houghton Mifflin, 1993), p220.

clear that he separates out the 'common people' from (presumably) the 'intelligentsia'. Implicitly asserted here is that there is an intellectual section of society uniquely capable of developing and responding to objective reasoned argument. Somehow they are immune to the irrational prejudices and desires that affect the 'common people'. Unlike self-proclaimed intellectuals like Perry the 'common people' are insufficiently capable of controlling their irrational emotions and responding to reasoned argument. On this view it is as if we all live on a level social, political, and economic playing field, with only the varying 'rational' contents of our heads to divide us. Moreover he makes an implicit distinction between intellect and 'the good life' on the one hand, and emotional experience and regression on the other. Intellect is preconceived to underlie all that is good in human activity and engagement. The value of feelings and emotions are diminished and delegitimized in this rendition of the 'truth' that history tells us.

Perry would no doubt agree with the views expressed, in 1922, by Hugh Crichton-Miller, the head of the Tavistock Clinic. Commenting on the 'sociological' aspect of 'man' and its connection with evolutionary development, he maintained that 'normal influences' worked on the race from top down, whilst 'mob hysteria' and its regressive impulse operated from below upwards:

'... where the higher intellects fail in providing the vision and passing it downwards, where they are not able to suggest the well-balanced solution, springing from creative ideas and harmonized with the lessons of history, there regression will take place. Mob hysteria, which wastes all the lessons of

history, because it cannot learn, and wastes much more that is valuable to society in its attempt to realise the one goal that it sees, will rule.'¹⁰⁶

Emotional Development situated within the hierarchy of Minds: Some Effects on Care and Treatment.

How then did mental hygienists' new history of emotional development, superimposed and intertwined as it was with extant histories of societal and mental development, impact upon care and treatment? As we have seen, mental hygienists described a history of personal emotional growth that was superimposed upon and mediated by histories of the progressive development of human societies and of individual minds. The problematic field remained the adjustment of the individual mind. It's reconfigured aspect was that, because of the centrality of emotional experience to this developmental process, the 'will' could not simply be self-asserted or re-activated, by the unrelenting force of it's application. What was needed was knowledge of the processes involved, and expert guidance to encourage this awareness. Nevertheless, mental hygienists remained confident of their own knowledge and authority regarding the general processes by which individuals became emotionally 'stable' and adjusted to societal norms. And, indeed, they appear to have been quite comfortable with their assumed ability to determine what those societal norms were and how people necessarily were required to adjust to them. As such the nature of the problematic continued largely to exclude any response from those who were its object, other than in terms of an acceptance of the need for treatment or of their 'nature' as recalcitrant. Excessive and distorted emotions, and

¹⁰⁶ Hugh Crichton-Miller, *The New Psychology and the Parent* (London: Jarrolds, 1922), p180-181.

thus immaturity, irrationality and deviance, remained obvious in terms of this problematic, while moral judgement and the potential bias and 'irrationalities' that might actually constitute the problematic itself continued to be invisible. On the other hand, this altered problematic clearly had consequences which entailed an altered orientation to authority from that of the older moral therapy. Overt authoritarianism towards those other than the 'mentally arrested' would not work; indeed it would likely hinder adjustment. What was required was, not unyielding domination, but shaping based upon expert knowledge of emotional development.

In the final two sections of this chapter I provide a brief impression of how these factors influenced mental hygienists' therapeutic approach. I look first at care and treatment of people categorized as mentally deficient, and second at that directed at 'normal' and 'maladjusted' people.

Mental Deficiency.

The mediating function of mental hygienists' description of progressive history and the development of the interiorized 'modern' mind is revealed in their distinct approach towards children they considered mentally deficient. Child guidance clinics discriminated against the treatment of these children. 'The study of mental deficiency', wrote Emanuel Miller, 'is concerned with the thinking (cognitive) or intellectual handicaps, largely because intelligence rather than any other function seems to suffer,'¹⁰⁷ On this view mentally deficient children's emotional lives and

¹⁰⁷ Emanuel Miller, 'Psychiatry of Children', p208.

behaviour difficulties were deemed mere consequences of intellectual incapacity. This was in contrast to children deemed to have other disorders. These, 'although manifest in symptom and behaviour', were conceived as the *products* of emotional difficulties.¹⁰⁸ This separation of mentally deficient treatment from normal and maladjusted children was reinforced in popular literature aimed at the general public.¹⁰⁹ The distinction in treatment between mentally deficient people considered to be mentally arrested at more primitive stages of development and more normal children displaying emotional maladjustment was reiterated. Mentally deficient people, 'primitive' and intellectually unsophisticated as they were, required proportionately simple and straightforward care and control. On this view, 'brute' feelings did not require sophisticated consideration in order to be shaped and 'stabilized'. Normal and maladjusted children, on the other hand, it was increasingly determined, required the 'greatest skill and understanding and an inquiry into, and understanding of, their environmental background.'¹¹⁰ The means of this division of the value and content of emotional experience thus rested upon intellectual ability and history: Below a certain level of measurement, feelings became transformed, from phenomena needing understanding and sympathetic guidance, to more 'primitive' forces requiring control and discipline. The latter could not conform to the delineated 'natural history' of emotional adjustment because they resided in a biological mind conceived to have already diverged and remained 'arrested' at an earlier stage of human progressive evolution; a stage less rational and civilized. Before intellect – brute expression; after intellect – sensitivity.

¹⁰⁸ Emanuel Miller, 'Psychiatry of Children', p208.

¹⁰⁹ For instance, I. G. Goddard, 'Careers in Child Psychology', *Women's Employment* 4th November, 1938. (Un-paginated reprint – MIND archives).

¹¹⁰ I. G. Goddard, 'Careers in Child Psychology'.

But although mental tests remained a key determinant in the segregation of mentally deficient people until well into the post-Second World War decades, evidence accrued from the First World War onwards showing that normed intelligence tests were limited as indicators of human capacities and differences.¹¹¹ Mental hygienists' conceptualization of emotional experience as intrinsic to growth and development encouraged an attention to wider traits of character.¹¹² Increasingly other temperamental and emotional factors appeared to be important in helping to differentiate between mental deficiency, 'backwardness' or 'maladjustment'.¹¹³ These attempts to objectively conceptualize emotionality and its role in personality in fact had an impact, albeit limited, in the care and treatment of mental deficiency. Its general influence was well expressed by a medical officer at Caterham Mental Hospital:¹¹⁴

Modern psychology has laid stress upon the importance of the instinctive and emotional factors in human life, and it is now universally recognized that a normal emotional equipment is at least as important a determinant of success in life as is a normal degree of intelligence. Certain failures, on the other hand, both of social adjustment and of specific ability, can be demonstrated as having their origin in the emotional sphere. It is justifiable to argue that emotional disturbance may produce behaviour reactions which closely simulate mental deficiency, especially when they occur in children of the

¹¹¹ Kurt Danziger, *Constructing the Subject : Historical Origins of Psychological Research* (Cambridge University Press, 1990), p158

¹¹² In his article, for instance, Gillespie emphasized that social and industrial harmony rested, not just on expertise in finding the correct employment according to intellectual ability, but also upon temperament.

¹¹³ See, for instance, Lucy Fildes, 'Performance Tests with Defectives', *Mental Welfare* 6 4 (1925) 88-93.

¹¹⁴ C. J. C. Earl, 'Emotional Factors in the Diagnosis and Treatment of Mental Defect', *Mental Welfare* 16 No.2, April 1935, 25-30, p25.

lower grade of normal intelligence. Not only that, but we must hypothecate a certain low level of intellect, or conversely a high level of emotional instability, at which the emotional factor may fairly be said to determine mental deficiency; whilst lastly, in the true intellectual defective, emotional factors may complicate the deficiency.

This was the emerging psychological view- in theory at least. Because mental hygienist's attention to subjective feelings was dictated by the problematic of the development of individual minds to social adjustment and competent citizenship, the bulk of people diagnosed mentally deficient remained, as I have just mentioned, pre-conceived to be outside the scope of this detailed attention. But emotional instability, it was now argued, could aggravate the problematic behaviour of mentally deficient people; this needed to be stabilized whether or not such people were perceived to need segregation. Such 'stabilization', however, rested upon relatively straightforward control and discipline. Those people referred to as 'borderland' cases were also open to this altered consideration. However, rather than reducing the remit of mental deficiency provision by placing into question the certification and control of people deemed feeble-minded, this reconsideration actually tended to encourage a theoretical extension of the mental deficiency system. Placing less emphasis on measured innate intellectual capacity and more on emotional 'stability' tended to raise the intellectual level at which some mental hygienists were prepared to diagnose mental deficiency.¹¹⁵

¹¹⁵ C. J. C. Earl, 'Emotional Factors in the Diagnosis and Treatment of Mental Defect', p28.

In terms of care and treatment, the main effect on mental deficiency was that leading mental hygienists began to speak of their work in terms of 'stabilization' and 'socialization'. Since 'social inefficiency' could not be adequately categorised by intelligence alone the training of 'character' and 'stability' was emphasized.¹¹⁶ The mental deficiency institution was now envisioned as the hub of a graduated system through which mentally deficient people could be spread according to their ascribed abilities and social competence.

This revised view on the relation of emotionality to character and conduct dovetailed with a growing appreciation amongst mental hygienists that institutional segregation alone was not a viable option to deal with the large number of people considered mentally defective who were estimated to be at large in the community.¹¹⁷ An expansion of institutional provision was still demanded, and many considered this the ideal 'solution', but this was now considered impractical as a complete measure. Instead an integrated system of institutional provision and community supervision was promoted. On this new view the institution would receive mentally defective people who had been ascertained and deemed to need more than simple supervision. Here they would be categorised, tested, trained and stabilized. Many, such as the 'low-grade custodial cases, the wet and dirty cases, the epileptics, the troublesome fighting cases, the high-grade unstable ones', and those who had committed sexual crimes, would need to be retained permanently. But many, it was now argued, could

¹¹⁶ Stanley Powell Davies, *Social Control of the Mentally Deficient* (London: Constable, 1930).

¹¹⁷ See, for instance, Ruth Darwin, 'The Proper Care of Defectives Outside Institutions' in, Central Association for Mental Welfare, *Report of a Conference on Mental Welfare Held in the Central Hall, Westminster, London, SW on Thursday and Friday, December the 2nd and 3rd, 1926* (London: CAMW, 1926) 23-35, p23-4.

be 'stabilized' and sent out on licence to 'smaller lakes'; these would include hostels and day work at nearby farms or local domestic work.¹¹⁸

This agenda proposing an extended scope for mental deficiency work coincided with economic constraints that served to encourage their adoption. Throughout the 1920s lack of institutional accommodation severely hampered the operation of the Mental Deficiency Act.¹¹⁹ The Board of Control responded by encouraging greater use of powers of 'licence'. Under the 1913 Mental Deficiency Act the law only allowed for the transfer, by judicial authority, of a mentally deficient person from guardianship to an institution.¹²⁰ It did not allow for transfer from an institution to guardianship. The only way that the latter could be achieved was by fully discharging a person from an institution and then applying for a new order. A circular issued by the Board of Control in 1924 suggested that licencing should be considered where there had been several years training through which good habits, some measure of self-control, and an ability to do simple work had been established. None should be placed on licence, however, who showed signs of 'erotic, unstable or violent tendencies'. The advantage of licence was that it allowed swift recall to an institution where deemed necessary. The Board emphasized that it was of the utmost importance to ensure that

¹¹⁸ F. Douglas Turner, 'The Aims and Objects of a Mental Deficiency Institution', *Journal of Mental Science*, July, 1928, 465-473, p469-70. An example of an early hostel for women from institutions is described in, *Studies in Mental Inefficiency* 5 (1924), p92. This was operated by a CAMW local association. It provided for 'high-grade defectives' who had 'already had experience of Institution life in an ordinary Certified Institution', and who had shown by their general behaviour that they were 'fitted for wider opportunities of increased liberty.' In the 1920's the Guardianship Society (closely associated with the CAMW) developed farm colonies for training young men. See, Louise Westwood, *Avoiding the Asylum: Pioneering Work in Mental Health, 1890-1939* PhD. Thesis, University of Sussex, 1999, p75.

¹¹⁹ See, for example, Board of Control 11th Annual Report 1925, cited in *Mental Welfare* 6 4 (1925), p97.

¹²⁰ The advantage of changing the law so that patients could be transferred from institutional care to 'guardianship' was that it would ensure more direct monitoring of behaviour and circumstances than the procedure of 'licence' where there was no systematic surveillance. A Bill, sponsored by Sir Leslie Scott, amending the Mental Deficiency Act on this basis was passed in 1925. See, *Mental Welfare* 6 4 (1925) p101.

a defective person's home was suitable. The circular went on to assert that 'discharge' in such cases was too experimental to be advisable.¹²¹ The Board had sole power of discharge. There were no powers for petitioning relatives to do so.

For profoundly mentally and physically disabled people, generally termed, 'cot and chair' and 'low-grade', the mental deficiency institution remained the environment generally agreed upon (by social reformers and the medical profession at least) as the most 'appropriate'. These people's needs were reduced to separate containment and medical care. In the case of people termed 'middle' and 'high-grades' (imbeciles and feeble-minded) mental hygienists continually promoted segregated institutional provision as a means of training as well as care. A pamphlet produced by the CAMW stated that:

It is a well-known fact that a child who has been trained for years in an Institution will deteriorate in the most deplorable fashion as a result of a few months idleness at home. In the same way, too, a low grade child left continuously without training is likely to remain helpless, dirty and uncontrolled; an almost intolerable burden on the Institution to which he must ultimately be sent.¹²²

On another occasion the CAMW complained:

From time to time parents privately or through certain sections of the press beg for the release of the mentally defective person, failing to realize that a

¹²¹ Cited in *Mental Welfare*, 5 3 (1924), p63-4.

¹²² Cited in E.J. Fitzgerald, 'Observations on the Training of Low Grade Imbeciles', *Mental Welfare* 19 2 (1938) 44-51, p47.

defective may do fair work in an institution, and be quite unable to manage his own affairs outside of an institution.¹²³

However, these actions on the part of some relatives seem hardly surprising considering that the Board of Control retained sole right of discharge and, as we have just noted, the Board believed that discharge was too 'experimental' to be advised in many cases.

Despite the promotion of more flexible control and supervision, the mental deficiency institution remained the point at which 'one-way' reason could be applied most directly, efficiently and productively. I mentioned earlier that on the diagnosis of mental deficiency, mental hygienists' conceptualization of emotionality became transformed. From phenomena that required skill and sensitivity in order to promote healthy mental adjustment and good citizenship emotions became 'primitive' forces requiring control and discipline. Categorization and separation into hierarchies of mind and behaviour inside institutions was a principal measure of this control and discipline. The Board of Control recommended that ideally for these administrative purposes mental deficiency colonies should cater for at least 1000 to 1200 'defectives'.¹²⁴ Likewise, the Metropolitan Asylums Board operated a careful system of classification that categorized mainly according to mentally deficient people's 'improvability' or 'unimprovability'.¹²⁵ Inherent in these measures was the concomitant understanding of emotionality as something largely innate and primitive. A recent

¹²³ *Mental Welfare*, 6 4 (1925), p98.

¹²⁴ Board of Control, *Suggestions and Instructions Relating to The Arrangement and Construction of Colonies for Defectives* (London: Board of Control, 1936) cited in, Patricia Potts, 'Concrete Representations of a Social Category: Consolidating and Transforming Public Institutions for People Classified as 'Defective' in, *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster: BILD, 2000), 43-67, p50.

¹²⁵ CAMW, *Studies in Mental Inefficiency* 15th October 1924 5 No.4 p93.

article by the educationalist Patricia Potts, which discusses how architecture has been a concrete representation of constructed social categories, notes that the diagnosis of mental deficiency entailed a relegation of considerations about the effects of surroundings on individuals' health and well being. Discussing the views of James Kerr, the Consulting Medical Officer to the London County Council during the 1920's, she shows that his appreciation of these potential psychological factors, evident in regard of children in elementary schools, was absent regarding mental deficiency.¹²⁶ Her remark that when it came to mental defectives his 'sensitivities disappeared' directs us to the real point of transformation in emotionality; it lay, not in an asserted lack of mental capacity in people deemed mentally deficient, but in the theories and attitudes of those directing their treatment. The Epsom Manor Institution, which promoted the more 'progressive' and flexible care and training, displays all of these factors.

The Manor Institution contained over a thousand residents. The Superintendent described its organization in an article written on request for the CAMW's journal *Mental Welfare* in 1924.¹²⁷ In it he decried prison-like regimes and propounded his own institution with its 'relative freedom' as the best means to improve behaviour and conduct. Here the sexes were allowed to mix at the weekly dance and at other organized occasions. Girl Guides, Brownies and Scouts associations were formed and freedoms and privileges allowed for them. Moreover, the wards for most male (but not female) residents over school age were unlocked. These residents were allowed to come and go to work and enter the gardens and recreation grounds at will.

¹²⁶ Patricia Potts, 'Concrete Representations of a Social Category: Consolidating and Transforming Public Institutions for People Classified as 'Defective', p49-50.

¹²⁷ The Medical Superintendent, 'The Manor Institution, Epsom: Some Comments on its First Two Years', *Studies in Mental Inefficiency* 5 2 (1924) 25-32.

And yet the picture this Superintendent painted of his institution seems anything but un-prison like. He himself expressed this clearly when he wrote: 'Our residents have been uninstitutionalised and are only gradually becoming so; experience goes to show that it is only a matter of time and organization in which normal brains generally outwit the abnormal'.¹²⁸ Indeed, it would be more apt to say that nineteenth century moral therapist's aspirations of 'total tutelage of the patient' were retained in this kingdom for the mentally 'arrested'.¹²⁹

The 'freedoms' described were freedoms to an end. As such they were constantly open to being revoked. As the Superintendent noted, the residents were considered to have primitive instincts 'unschooled in inhibition', and as such they required constant surveillance and discipline. Relative freedoms and choices were the substantive rewards of accepting one's definition and proving one's ability to learn responsibility within the scope allowed by this definition. The main method of control consisted of classification and a system of rewards and privileges. Both sexes over school age were divided into four classes, each class carrying different rewards and privileges. Residents could be promoted or demoted through the classes according to their behaviour. Record books containing staff judgements of residents' attitudes and conduct were kept continually. Unpunctuality, misbehaviour or laziness received negative marks and could result in loss of privileges or demotion to a lower class. This removal of privileges was widely defined. It included confinement to bed and 'on the very rarest of occasions a simplified diet'.¹³⁰ Positive marks were awarded for

¹²⁸ The Medical Superintendent, 'The Manor Institution, Epsom, p32.

¹²⁹ This reference to nineteenth century moral therapy is taken from Robert Castel, 'Moral Treatment: Mental Therapy and Social Control in the Nineteenth Century', p257.

¹³⁰ The Medical Superintendent, 'The Manor Institution, Epsom', p29.

efficient work in the institutional workshops or wards, and good general behaviour.

The guide and scout organizations represented further elements of this system of control and training through promotion and demotion. They represented the highest rungs of the institutional hierarchy. Once accepted into their ranks members were allowed extensive parole to go about unattended in the institutional grounds. The lodges could also occasionally invite outside friends to visit once their names had been submitted to, and approved by, the Medical superintendent.¹³¹ The Superintendent noted that it was only from the ranks of the Guides that selected women had been 'permitted' to work as domestic service outside the institution, either daily or on licence. Similarly it appears from his remarks that it was only from the ranks of the scouts that some boys were allowed home for the day unaccompanied.¹³²

This then was a system of constant surveillance, judgement and control; a relentless neo-moral therapy. Only a few years earlier Franz Kafka had written a short story called 'In the Penal Settlement' in which inmates were placed inside an 'inscription machine' that engraved upon their bodies the nature of their crimes.¹³³ It might well have been written about the people detained in such mental deficiency colonies. For, just as at the penal settlement, these people were inscribed over and over again with the nature of their condition - with the condition of their being. This was a world in which inmates were cast into a continuing uncertainty, of perpetual judgement and fear of being found at fault. Liberty, and therefore citizenship and rights, were here of a substantive nature and defined by self-appointed experts. Any desire for the kind of liberty or choice that others in society took for granted was dependent in these

¹³¹ The Medical Superintendent, 'The Manor Institution, Epsom', p28.

¹³² The Medical Superintendent, 'The Manor Institution, Epsom', p29.

¹³³ Franz Kafka, 'In the Penal Settlement' in *Metamorphosis and Other Stories* (London: Secker and Warburg Ltd, 1933). The short story was first published in German in 1919.

circumstances upon, either an acceptance of one's nature as defined by those in control and an acquiescence in the means designated for making oneself a 'responsible citizen'; or escape. Many appear to have tried the latter.¹³⁴

Maladjustment

The difference in approach to emotionality here is striking. It is here that the shifted moral therapy problematic deployed by mental hygienists between the wars is most apparent. Moral therapy had applied an unrelenting 'eye', in a battle of wills. It attempted to fix and neutralize a patient's emotional excesses through an external will aimed at re-establishing an internal will. Mental hygiene held to a wider remit directed at promoting 'adjustment' and treating 'maladjustments' in society as a whole. Excluding those people whose minds were considered to be 'arrested' they held that emotional irrationalities were a necessary feature of mental growth and adjustment. These were common to all and required an educational therapy that crafted rather than diminished or neutralized emotionality. Directed at childhood this became an attempt at a firm but gentle shaping and nurturing along 'right lines'. Children needed understanding so that they could develop with the grain of human historical development. Thus, the 'primitive' emotional and intellectual stages of childhood required a tolerant eye:

¹³⁴ The Superintendent claimed that, although 'absconders were naturally pretty numerous', the Manor experienced relatively few. These escapes, he lamented, were the result of connivance by relatives followed by their concealment of the child. Resort to court proceedings, he complained, was fraught with difficulty since it often resulted in defendants providing 'malicious statements and lies' to local papers. The Medical Superintendent, 'The Manor Institution, Epsom', p32.

It is therefore essential for the normal growth of children that parents, where they do not know themselves, should efface themselves as much as possible, and like good gardeners they should merely watch the growing tree, giving it air, sun and moisture, but careful in restraining the pruning hook, or forcing branches in directions which they do not wish to take, and so obviating the danger of producing, not normal plants, but horticultural curiosities. Such curiosities are not infrequently to be found amongst children of conscientious parents with fads and principles – a danger to such a delicately growing thing, but with such powerful urges as the human child.¹³⁵

With their emphasis on the importance of childhood development for mentally healthy adjustment to good citizenship, mental hygienists considered child guidance clinics to be crucial to social health.¹³⁶ In child guidance children's emotionality was investigated in detail. Emanuel Miller described the investigation of children deemed to be suffering problems of emotional development this way:

These reactions can be explained only by examining the psychological structure of the child's mind, the part played by and destiny of his instinctual needs, and the way in which these have been moulded by his earliest experiences. ... the practitioner must ... study the total personality of the child, firstly as presented in a cross-section and secondly, as the history of a developing mind struggling for satisfaction and breaking down in the course of attempted adaptation. The practitioner now views the child not solely as a neuro-metabolic machine but also as a feeling, thinking, and striving human

¹³⁵ Emanuel Miller, 'The Mind of the Child', *Mental Hygiene*, no. 7 July 1933, 68-71, p71.

¹³⁶ A. Helen Boyle, 'The Prevention and Treatment of Nervous Breakdown', *Mental Hygiene* No.4 December 1931 9-14, p12.

being whose basic instinctual needs have been disturbed and his relations to the external world consequently distorted.¹³⁷

Intimate studies of the child's demeanour, its fears and anxieties, its history of development and family background, were all carried out in order to create a picture of the 'whole child' and detect the clues to its maladjustment. This firm but gentle approach was also directed to adults. Problems of adjustment displayed in adulthood were largely attributed to faulty upbringing mediated by constitutional factors. Psychotherapy could help to bring some to realize the 'primitive' fears that underlay much of their adult problems. Such detailed and fine tuned studies were, as we have seen, notably lacking in care and treatment of people categorized as mentally deficient.

But, even here, mental hygienists considered themselves to be looking through a frame of reference rather than standing within it. Their shifted problematic reinterpreted some social norms, such as their contention that mental troubles could not be simply held in check by a continual self-assertion of the will, and their perception of the need for emotional security and freedom from fear. However, they isolated 'faulty' personality and adjustment largely in terms of straying from generally accepted social norms and contemporary social problems. In turn they attributed much of the cause of these maladjustments-, which included, delinquency, crime, and deviations from commonly accepted gender and sexual behaviour- to faulty childhood upbringing. This, and the utilization of outlines of historical change, represented a functionalist view in which people and institutions were interpreted in terms of their

¹³⁷ Emanuel Miller, 'Psychiatry of Children', p207-208.

function and fit for society and its progress. With such an approach mental hygienists could remain largely unreflective about the bases of their assumptions about 'health' and of their own prejudices. The most obvious of these centered around a privileging of constructions of intelligence as the means to order an hierarchical society, and an associated relegation of issues of class, gender and sexual roles.

One practitioner of the New Psychology, for instance, divided his patients broadly into co-operative and non-co-operative types. The former were 'receptive and submissive' ready to see what was shown them. The latter were argumentative and hostile, 'using neurosis to gain their own ends'.¹³⁸ In the case of co-operative patients, therapy could usually proceed relatively smoothly through three stages. The first stage was to study the 'infantile prototype and goals' seeking evidence of early adjustment or maladjustment in relation to society (construed as equivalent, at this infant stage, as the nursery), sex (intimate relations and games), work (school) and family. Particular emphasis was placed on early screen memories. Such earliest memories as 'I was playing by myself' being extrapolated to indicate the likelihood of a 'non-social' type, and self-loving masturbator.¹³⁹ The second stage of therapy analysed the present situation of the patient while the third stage was characterised by the gradual introduction of interpretations. Non-co-operative patients could not be taken through these stages until their hostility was abated either simply through the defenceless and resentment-proof attitude of the therapist, or if this failed, the instilling of obedience. Curiously, this instilling of obedience was to be achieved,

¹³⁸ Alan Worsley, 'The Approach to the Patient', (From a speech to the Medical Society of Individual Psychology, 14th March 1940) in, *Early Phases of Medical Psychology, History of the Society, Post War Planning, Active Psychotherapy in War-time, The Approach to the Patient, Analysis Under Hypnotics* - Sir Walter Langdon-Brown and Drs O H Woodcock, Alexander Baldie, Wilhelm Stekel, Allan Worsley, Culver Barker, H V Dicks and Ellis Stungo, (London : The C W Daniel Company Ltd, November 1943), 28-33, p28 and p31.

¹³⁹ Worsley, 'The Approach to the Patient', p29

according to Worsley, by unhelped free association 'even if it means hours of refusing to speak at all'.¹⁴⁰ In other words a return to a more classical psychoanalytic stance. It was hoped that through these means the patient could be brought to overcome his fears and master the adult situation.

The authoritarian and moralising tones of the 'therapy' just described are clear. Patients are 'uncooperative' if they refuse to see that the therapist is more enlightened than they are. Rejection of the therapist's interpretations is seen as wilful disobedience. As a consequence the patient must be 'disciplined' into a 'receptive and submissive' frame of mind by the silent power of the therapist. A frame of mind where, to say the least, dubious suppositions, such as that the patient is a 'self-loving masturbator' will be accepted as reasonable extrapolations from an early memory of playing on one's own. Also apparent here, however, is the shift away from overt authoritarianism and, instead, an emphasis upon a more restrained authority engaged in an attempt to prompt and nurture an in-built drive towards adjustment to (pre-determined) societal norms.

Nevertheless, this attention to emotionality as one of firm but gentle concern continued to elide 'femininity' with emotional indulgence and lack of objectivity:

The mother is the center-piece of the family when it is a matter of describing the family neurosis, but it is to the father we must look when it comes to prognosis and treatment. He more than anyone else will have an effective influence on his wife and children if we can release his normal masculine

¹⁴⁰ Worsley, 'The Approach to the Patient', p31

impulses. He will then encourage what is normal in his wife, but even more important is the influence which he will bring to bear directly on his children. He will make his daughter proud and happy in her femininity and give his sons an example they can follow with pride.¹⁴¹

As I have emphasized in this chapter, interwar mental hygiene continued to employ descriptions of progressive history as a foundation for their knowledge. In particular, an appreciation of the historical nature of personhood was considered a necessity in order to hold together the social and moral order. Hierarchies of historical development dovetailed with hierarchies of the mind which in turn dovetailed with hierarchies of the present social and moral order. Attitudes to the childhood 'problem' of masturbation reflect much of this. Masturbation had increasingly come to be reconsidered under mental hygienist's altered problematic. It had become reinterpreted from the image of, sunken-eyed and listless degenerates, whose mental capacity and germ plasm had been corrupted by their own indulgent self-pollution, so frighteningly documented by asylum doctors such as Maudsley. Masturbation was now increasingly considered as a potential symptom of mental troubles rather than the cause of them.¹⁴² Nervous breakdown due to 'self-abuse', where it did appear to occur, was due less to the nature of masturbation itself than to mental conflict engendered by the wrong attitude. This wrong attitude on the part of the 'patient' was due in turn to the wrong attitudes of the 'patient's' parents. Masturbation was associated with the instinctual sex drive, a drive that ensured the survival of the race. Thus the sex drive

¹⁴¹ W. Paterson Brown, 'The family neurosis', in, R.G. Gordon, *A Survey of Child Psychiatry*, (London: Oxford University Press, 1939), 115-127, p126.

¹⁴² R.G. Gordon, conveniently forgetting past warnings by prominent psychiatrists of the perils of 'self-abuse', blamed the belief that excessive masturbation led to insanity or mental deficiency on the subjective and partial views of the laity. See, 'Habit Formation', *Mental Welfare* 14 2 April 15th 1933 29-37, p36.

needed to be understood and accommodated within the complex demands of advanced civilization. It was neither to be simply accepted nor encouraged however. Indeed, despite this reconfiguration we have not strayed far from Helen Bosanquet's outline of the COS casework relationship described earlier. The continued prevalence of Social Darwinist attitudes is clearly evident here, as indeed it was in other mental hygienist writings.¹⁴³ R.G. Gordon, the Director of the Child Guidance Council, used the analogy of hunger to describe this view of masturbation and the sex drive. He maintained that:

It is generally agreed that those human races who live in places where food grows literally readily to hand so that they have to make no effort to gratify the appetite of hunger and so to preserve their individual existence, do not advance very far in the scale of civilization. The people that come out on top, in the long run are those for whom individual survival is a continuous struggle, requiring the exercise of those qualities which human beings enjoy in contradistinction from the animals, in virtue of their more highly organised nervous systems.¹⁴⁴

As with hunger, so with sex; civilization could never proceed on the basis of people gratifying their 'low level' impulses.¹⁴⁵ Just like hunger, the sex drive was an appetite that needed to be accommodated but also understood so that it could be regulated. Self-indulgence learned in childhood would likely lead to anti-social attitudes and the lack

¹⁴³ See, for instance, William Brown, 'Character and Personality', *Mental Hygiene* No.13 April, 1935 54-56, p54; J.A. Hadfield, *Psychology and Mental Health* (London: Green Allen and Unwin, 1950). J. R. Rees, *The Health of The Mind* (London: Faber & Faber, 1929), p21, 64 and 158.

¹⁴⁴ R.G. Gordon, 'Habit Formation', *Mental Welfare* 14 2 (1933) 29-37, p36-7.

¹⁴⁵ R.G. Gordon, 'Habit Formation', *Mental Welfare* 14 2 (1933) 29-37, p37.

of a responsible altruistic disposition towards the good of society. Healthy mental development was, to mental hygienists, development to responsible citizenship.

Chapter Three.

Emotions Situated in the Web of Relationships: 1.

Introduction

We have seen that as mental hygienists transferred moral therapy to the wider community they deployed descriptions of progressive history as an authoritative foundation for their expertise in defining individual and societal health. Between the wars they built on generally accepted notions of the past as evolutionary and progressive to describe an historical process from 'primitive' to 'civilized' through which subjective identity and experience became individualized and interiorized. Both intellect and the emotions slowly transformed from externalized control by the 'group' to inward disciplining within the mind. Mental hygienists did not want to promote individualists however. Like the British Idealist philosophers they were concerned about the tensions between the developments they described and the need for social cohesion. Their concept of mental hygiene was one of functional fit and social harmony. This was a conceptualization of mental health as permeated by fears about the social and moral order. For mental hygienists, unawareness of the indissoluble historical nature of personhood made people potentially both dangerous and vulnerable. They were vulnerable to 'regressive' influences in society, and they were dangerous because, in so being, they could become carriers of this social 'ill-health'.

People diagnosed mentally deficient represented the quintessential examples of this. They were living examples of 'arrested' history. They inhabited a 'primitive' emotionally subjective world dominated by the temporally and environmentally

proximate, and unchecked by adequate intellectual reason. The infants and developing children of the 'normal' population mirrored many of these characteristics, but with appropriate guidance grew through them. If maladjustments, and mental disorders developed, these represented blockages and deviations from normal stages of development. In these cases the recapitulation of historical stages of growth embodied in the child's personal development had become stalled and distorted. Like mentally deficient people they were considered to be more preoccupied with immediate experience than with social responsibility. They had not developed with the grain of history. But interwar mental hygienists believed that, if caught early enough, these maladjustments could be treated. They conceived the emotionality, which they linked to individual and social ill health to be an inherent and necessary aspect of personhood common to all. Other than in the case of those they designated intellectually 'inferior', mental hygienists believed that emotionality needed to be understood so that it could be shaped and accommodated by the intellect. In 'normal' life this was first done within the family via the external 'will' of parental guidance, and gradually internalized. Mental hygienists therefore attempted to provide expert guidance on how best to do this.

This interwar view represented an alteration of the moral therapy problematic.

Autocratic authority that sought to dominate and subdue emotionality was inconsistent with a full appreciation of the nature of personhood, and as a consequence, potentially harmful. Emotionality needed tolerant but firm shaping. Associated with this, the use of fear, which had been a part of nineteenth-century moral therapists' armoury, was highlighted as detrimental to mental health.

Two principal issues arise so far from this story of the re-deployment and reconfiguration of the moral therapy problematic out towards the wider community. The first is that, though fundamentally concerned with the nature and rights of citizenship, mental hygiene cannot be considered to have much in common with the position of defending the civil rights of mentally disordered and mentally handicapped people that was adopted by MIND in the early 1970's. The second issue I want to highlight here is an ironic one. What tracking mental hygiene in this way shows is that, though interwar mental hygiene has little in common with a later strategy which sought to assert the civil and social rights of the mentally disordered *themselves*, it does have important similarities with strong social constructionist accounts of the power of medicine and psychiatry in creating the contemporary 'self'. As we have seen, both use delineations of history as an objective authority that justifies their definitions of personhood. Both posit an historical process of interiorization of subjective identity and experience. Both engage with emotionality only in terms of a subjective economy that is fashioned and shaped by intellectual knowledge and practice. Strong social constructionist accounts thus have important commonalities with the neo-moral therapy peddled by mental hygienists between the wars.

I return to these commonalities and what they entail in the final two chapters, but in the following three chapters I trace out some consequences that developed from mental hygienist's attention to emotionality which these strong constructionists fail to confront. The power of mental hygiene was founded on delineations of historical progress; for mental hygienists this was both evolutionary and biographical. Around this was constructed an image of mental health understood in terms of a graded

hierarchy of function and fit. Measured intellect played an important role in this touted differentiation and distribution. It served to differentiate treatment as well as social role. Mental hygienists claimed an expertise in defining categories of adjustment and maladjustment, and a right to influence the internalization of social norms that they deemed to be functional pre-requisites of healthy and 'efficient' individuals operating in a harmonious progressive society. However, in the following three chapters I trace out a further shift in mental hygienists' problematic that in fact conspired to undermine this functionalist, and one-way, vision of mental health. This entailed a move, from seeking to understand and act upon emotionality as something essentially rooted in the individual mind, to considering emotionality as a dynamic relational phenomena. Looking at emotionality in terms of the details of its relational context completely undid mental hygienists' programme of neo-moral therapy. The following chapters show how the ultimate logic of this frame of reference affected mental hygiene.

In this chapter I draw together several sites of experimental mental hygiene intervention during the Second World War and show how this altered approach underpinned all of them. I look at therapeutic community experiments developed at Northfield hospital under the aegis of the military, the Civil Resettlement Service designed to rehabilitate ex-servicemen back into the community, and the Social After-Care Scheme which attempted to provide a rehabilitation service in the community for military (and later civilian) psychiatric cases. What I believe is important to all these schemes is that they show that attending to the sensitivities of emotionality in terms of a relational milieu had consequences for hierarchical power and authority. Though mental hygienists continued with their pre-war agenda, *within* these sites of care and

therapy, hierarchy and authority became partially subverted. Concomitantly, freedom and choice transformed from possible ultimate goals of treatment, to important elements of therapy itself. As we will see in the following chapters, this altered view came to inform and interact with civil libertarianism in the ensuing decades.

Situating Emotions in The Web of Relationships.

David Armstrong has provided an influential account of transformations in medical theory and practice that shifted from analysing the details of the body to tracking the interstices between bodies. He maintains that, where nineteenth-century medical attention had been focused upon the detail of the individual body, from the early decades of the twentieth-century this attention turned outwards to a focus on the 'undifferentiated space between bodies'.¹ The bulk of Armstrong's description is produced through analysis of medical techniques of mapping and monitoring disease in the social body. And certainly the increase and refinement in the use of social surveys and the growth of the social sciences provided new techniques for the investigation and classification of both the individual and the social body.² Illness was becoming monitored in the population at large. It was not simply located to a specific point in the social body, but traced to the fluctuating spaces between people and in the 'interstices of relationships in the social body itself'.³ Thus, what Armstrong calls the new medical 'gaze', not only located pathology geographically in the population, as had been done during epidemics in the

¹ David Armstrong; *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983), p6

² Roy Porter; Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain in Freeman, Hugh and Berrios, German E; (eds) *150 Years of British Psychiatry, Vol. 2: The Aftermath* (London : The Athlone Press Ltd, 1993), p393

³ Armstrong; *Political Anatomy of the Body*, p8

nineteenth century, but through screening and surveillance of patient contacts, located it in social relationships.

Armstrong also traces a further extension of this 'gaze', however. This encompassed the mind and 'minor' mental troubles. From the interwar years, he argues, 'mental instabilities' – still rooted in individual minds - began to be delineated and tracked, in the same way physical illnesses had come to be, as fluctuating in the social body.⁴ But, he argues, there was a further development, stemming from around wartime, whereby these problems of the mind, came to be conceived as actually manifest in relationships themselves.⁵

The transformations in medicine that David Armstrong describes were in fact, coterminous with the growth of the social sciences.⁶ In the 1930's, for instance, Elton Mayo's studies of industrial relations and the importance of nurturing good human relationships became highly influential in the US and Britain. They had an impact, not only in industry, but also more generally in sociology.⁷ Moreover, psychiatric and psychological conceptualisations of the relations of individuals in the community united with those of sociology around notions of social adaptation and adjustment. Particularly closely associated to mental hygiene were the reconfigured approaches emerging in the discipline of psychoanalysis. Recently, the psychoanalyst Joseph Schwartz has described these as the beginnings of a 'paradigm shift' in psychoanalysis. Schwartz argues that the classical psychoanalytic generalization of

⁴ David Armstrong; *Political Anatomy of the Body*, Chapter Three, 'The Invention of the Neuroses'.

⁵ David Armstrong; *Political Anatomy of the Body*, Chapter Six, 'Disciplines of the Survey: 1. Child Life and Health', p59. But see throughout.

⁶ David Armstrong acknowledges this in a postscript to his work, p113-117.

⁷ Elton Mayo, *Human Problems of an Industrial Civilization*, (London: MacMillan, 1932) and, *Social Problems of an Industrial Civilization*, (London: Routledge and Kegan Paul, 1949).

an internal psyche seeking tension reduction through the satisfaction of desires has been transformed, through the twentieth-century, by the emergence and gradual elaboration of a general theory of human personality conceived in terms of the need for human relationships.⁸ He traces the theorists of this transformation essentially to Melanie Klein, John Bowlby, Ronald Fairbairn, and D.W. Winnicott. In fact, all of these analysts can be considered contributors to mental hygiene. In Britain, partly under the influence of Kleinian theories of child development, the mental hygiene movement increasingly began to consider problems of 'maladjustment' in terms of the details and quality of emotional relationships, particularly those of childhood. The psychoanalyst Susan Isaacs was influential in this area. She outlined a psychoanalytic description of the subjective experience of children in their relationships and how these affected psychological growth and development.⁹ Isaacs published the results of her investigations at the Malting House School as an explicit contribution to the movement for mental hygiene.¹⁰ With such work, primacy slowly began to shift from shaping emotions in the individual mind to tracking and moulding them as they manifested themselves in relationships.

In the United States too, psychoanalysts and sociologists were uniting in their attempts to conceptualize the individual in relation to the community. Both groups utilized notions of social control and social deviance as conceptual principles.

Lawrence K. Frank, for instance, published an article in 1936, in which he used these terms to argue that Western European cultural disorganization was responsible for

⁸ Joseph Schwartz, *Cassandra's Daughter: A History of Psychoanalysis*, ((Harmondsworth: Penguin, 1999), p12.

⁹ Susan Isaacs, *The Nursery Years* (London: Routledge, 1929); Susan Isaacs, *The First Two Years* (London: Routledge and Kegan Paul, 1937); Susan Isaacs, *The Nursery Years* (London: Routledge, 1929).

¹⁰ Susan Isaacs, *Social Development in Young Children: A Study of Beginnings*, (George Routledge and Sons, 1933), p16. Isaacs also published articles in *Mental Hygiene*, and *Mental Welfare*.

what appeared to be individual maladjustment. For him, society provided people with no consistent and attainable values.¹¹ Also during the 1930's the psychiatrist Harry Stack Sullivan developed his 'inter-personal' theory of mental illness based on his work with schizophrenic patients. He emphasized the communicative nature of psychotic experiences and the influence of other social factors, primarily personal relationships.¹² In 1937, the *American Journal of Sociology* brought together sociologists and psychoanalysts to provide a special issue on the fruitful links between their disciplines. The Hungarian émigré psychoanalyst Franz Alexander provided a paper in which he argued that sociology could greatly inform psychoanalysis of the specific sociological and historical formations within which psychological mechanisms were made manifest. Similarly to Frank, he suggested that society needed to be treated as well as the individual. Alexander maintained that the two disciplines could provide the scientific knowledge necessary for social groups to adjust to social structures.¹³ Coupled with this was his emphasis that primitive destructive drives in individuals required formal systems of social control. Sullivan also contributed a paper. He advocated psychological and psychoanalytical training for social scientists so that they could interpret the 'private history of great events'.¹⁴

These developments were to become significant to mental hygiene in Britain. In fact, all of these theorists were later to be prominent amongst the organizers and contributors to the Third International Conference on Mental Hygiene, hosted in London by NAMH in 1948. Indeed, through wartime interaction, and post-war

¹¹ Reprinted in, Lawrence K. Frank, *Society as the Patient: Essays on Culture and Personality* (New Brunswick, New Jersey: Rutgers University Press, 1948), p 1-5.

¹² For a good exposition of his work see Patrick Mullaney, *Psychoanalysis and Interpersonal Psychiatry: The Contributions of Harry Stack Sullivan* (New York: Science house, 1970).

¹³ Colin Sumner, *The Sociology of Deviance: An Obituary* (Buckingham: Open University Press, 1994), p109-111.

¹⁴ Colin Sumner, *The Sociology of Deviance*, p115, fn4.

collaboration with leading British mental hygienists, a general theory of 'human relations' became central to the mission of mental hygiene. In chapter four I look at how the shifted mental hygiene problematic was expressed at the London conference.

In the following sections of this chapter I trace this alteration of attention as it was developed and expressed at key sites of intervention during the war. To begin with I look at this shift as it took place in childcare, the root of the mental hygiene approach. Almost all of the above theorists placed the need to reform child rearing practices at the centre of any attempt to ameliorate 'social disorganization' and individual maladjustment by ensuring adequate socialization. As such they continued and developed this mental hygiene focus. Cultural integration was the aim, and attention to the emotional life of childhood the primary target. Analysis of emotionality and behaviour in terms of the details of relationships was seen as a means through which to conceptualise the links between individual experience and action, on the one hand, and social structure on the other. I want to reiterate here, however, that the backbone of the mental hygienist view was that, not only society, but personhood itself, was indissolubly historical: Individual development carried and recapitulated stages of human evolution. As a consequence, even with this new engagement with emotionality in terms of its relational phenomena, mental hygiene retained starkly different assumptions about the requirements of care for children and young adults categorized as mentally deficient. I therefore contrast mental hygienists' approach to 'normal' and 'maladjusted' children with that towards those deemed mentally deficient.

Shifting Towards Confronting the Dynamics of Relationships but Continuing Mental Hygiene's Pre-war Agenda.

In 1939 the Feversham Committee had recommended the formation of a unified national voluntary mental health association. This was to be created by the amalgamation of the National Council for Mental Hygiene, the Child Guidance Council, the Central Association for Mental Welfare and the Mental After Care Association. The latter declined to join and threat of war prevented full consideration of the Report.¹⁵ However, due to fears of mass public panic and breakdown the three former organisations joined together with the Association of Psychiatric Social Workers (APSW) to form a Mental Health Emergency Committee. By 1942, the committee had been renamed the Provisional National Council for Mental Health. It encompassed all the organizations except the APSW. Just after the war this organization became fully incorporated as the National Association for Mental Health (NAMH). For the sake of clarity, in this chapter I use the title NAMH to refer, both to the Provisional Council, and the later NAMH itself.

Soon after the outbreak of war the Mental Health Emergency Committee undertook the task of supervising the psychological and social issues of evacuation. It set up regional offices in the thirteen civil defence regions, under the control of trained psychiatric workers. These offices worked closely with government Ministries and local authorities supervising and helping to organise wartime hostels and organising

¹⁵ Anderson; 'The Development of the Voluntary Movement in Mental Health' in *The Mental Health Year Book 1981/82* (London: MIND, 1982), p431-2; Susannah Strong, *Community Care in the Making: A History of MACA 1879-2000* (London: MACA, 2000), p33-35.

billets for misplaced children.¹⁶ Later in the war their supervisory activities were extended to include residential Homes in existence prior to the war. They also provided advice on children who showed particular problems of adjustment to residential Homes or to billets. By the end of the war these advisory activities had extended further still to encompass Public Assistance Homes and residential nurseries. With regard to the latter, specially trained experts visited nurseries across the country. These workers advised both nursery staff and local authorities on the organisation and running of day and residential nurseries. During the course of the war this service was extended to some Public Assistance nurseries as well as those run by private and voluntary bodies.¹⁷ Visits to any particular area could be prolonged, covering anything from a week to three or even six months. Conferences to provide advice and assistance for nursery staff were also arranged on behalf of the Ministry of Health and local officials. Moreover, from 1940, and also on behalf of the Ministry of Health, the Emergency Mental Health Committee and the later NAMH organised two-week training courses for evacuation hostel workers.

On the basis of this activity NAMH attempted to set the agenda for child care provision and training. A number of pamphlets were produced, during the war, aimed at providing advice to child care workers and the public alike on child care, both within the family and in institutions and nurseries.¹⁸

Central to the mental hygienist problematic was the assumption that childhood upbringing in the nuclear family was the primary means through which individual

¹⁶ Ruth Thomas; *Children Without Homes: How can they be compensated for loss of family life?* p8

¹⁷ Ruth Thomas, *Children Without Homes* p8-9

¹⁸ For example; The National Council for Mental Hygiene, *Nocturnal Enuresis* (London: NCMH, 1940); and *Psychological Training in the Nursery- Three Talks for Parents* (London: NCMH, 1939). See also subsequent publications discussed in the text.

adjustment, social efficiency and thus 'democratic civilization' rested. The dynamics of emotional interaction were now a crucial part of this view. In the autumn of 1944, for example, NAMH produced a pamphlet on 'The Care of Children Away from their own Homes'.¹⁹ 'Family feeling', it announced, 'is the basis of society and anything which threatens its strength attacks the structure on which civilisation depends'.²⁰ To mental hygienists there was 'now an organised body of knowledge about the mental and educational growth of children, and of the means whereby 'aberrations in growth' could be remedied'.²¹ They propounded that: 'Just as simple rules of hygiene are generally accepted, so we should demand universal standards of children's welfare to include the mental as well as the physical'.²² Inter-personal relationships were now more directly centered on in descriptions of this development.

The family was understood to be the locus of relationships, which were critical to the mental health of children through stages of development to adulthood. The very young child required the largely physical care of food, sleep and warmth. By the second year, however, the child was aware enough for a relationship of trust and companionship to be required. Separation at this critical stage would lead to anxiety in the child and could be a key factor in later maladjustment and mental ill health. If such a relationship were maintained, however, a reciprocal loving relationship would develop so that the pleasure and displeasure of parents would provide the child with a personal ideal and allow it to absorb the civilized authority of its parents. Later child growth instilled the understanding that the child had an equal and not an exclusive place within the family

¹⁹ Provisional National Council; *The Care of Children Brought Up Away From Their Homes* (London: Provisional National Council, October 1944)

²⁰ Provisional National Council; *The Care of Children Brought Up Away From Their Homes*, p2

²¹ Cited in Provisional National Council, *Second Annual Report for the Two Years, April 1st, 1944 to March 31st, 1946*, p26

²² Robina Addis; 'Children's Homes' *Social Work* October 1944 87-91, p87.

group. This, and the child's later development of contacts out into an extended group of neighbours and friends, provided stepping-stones to wider community life.²³

But although it was considered organized and scientific knowledge, this discourse of emotionality was, nevertheless, founded upon an idealized 'normal' family in which bonds of shared experience and understanding were assumed to naturally produce mentally healthy growth and adjustment. As Lucy G. Fildes, one of NAMH's senior psychologists, announced to a conference in 1946,

'I come then simply to lay before you certain specific needs of children, that modern investigation has turned from what was perhaps implicit knowledge in some to general proven knowledge which can be handed on to all.'²⁴

In the 'normal' family continuous and psychologically nurturing relationships were not actively thought about, they simply happened. It was such relationships within the family which allowed the child's 'inner nature' to develop in accordance with his inner emotional needs.²⁵ But, in fact, the 'normal' home remained largely unanalyzed. Moreover, the 'normal' family was as much a target for advice on correct family relations, as institutional Homes and their staff. The inherent contradictions of this view were clearly apparent in the preface to a 1945 report by NAMH on childcare provision. In it Ruth Thomas, at that time NAMH's Senior Educational Psychologist, expressed the view that:

²³ Ruth Thomas, *Children Without Homes*, p21-23.

²⁴ Lucy Fildes, 'The Care of the Homeless Child', *Report of the Proceedings of a Conference on Mental Health Held at St. Pancras Town Hall, London, N.W.1, 14th-15th, November, 1946* (London: NAMH, 1946) 58-62, p59.

²⁵ Provisional National Council; *The Care of Children Brought Up Away From Their Homes*, p2-3.

Real progress [in child care] is only assured when it is possible for the values for which the social services stand to become in fact the values of the good family which automatically then takes the management of its own difficulties into its own hands. In the programme which we have now set ourselves, first to ensure a sound economic basis for family life and adequate services in the spheres of health and education aiming at family enlightenment as well as direct therapy, lies the most profound hope for future good citizenship.²⁶

The areas of childhood development deemed important as targets for 'correct' mental hygiene continued to be those in which aberrations were conceived as antecedents of contemporary social problems.²⁷ Thus a pamphlet produced by the NAMH in 1944 in its promotion of a 'simple "ABC" of the child's "needs"', maintained that wartime conditions were causing family cohesion to breakdown with dangerous consequences for the development of individual mental health and social efficiency in general:

That this break up of family life has profound effect is clear enough from the thousands of examples seen. Social problems appear, such as a rise in juvenile delinquency, due in part to the absence of parental authority, and an increase of sexual relationship outside marriage, which may be ascribed to lack of good family influence, and failure of the individual to assume social responsibility.²⁸

In essence this approach continues, as before the war, to take for granted the legitimacy of many dominant norms. Terms such as socialization and development to 'emotional adjustment' were anything but value neutral. Mental hygienists, for example, had

²⁶ Ruth Thomas, *Children Without Homes*, p7.

²⁷ Kurt Danziger, *Socialization* (Harmondsworth: Penguin, 1971), p20.

²⁸ Provisional National Council; *The Care of Children Brought Up Away From Their Homes*, p2

demanding psychological knowledge be applied to dealing with juvenile delinquency before the war. And during the war they drew attention to an apparent rise in prevalence.²⁹ In doing so they unreflectively reasserted many cultural prejudices. But, also as before the war, mental hygienists' conceptualization of children's emotional development disrupted some of these social norms. Some were thrown into question. Others were placed into a new perspective at the same time as they appeared to be reinforced. For example, a controversial report on juvenile delinquency prepared for the Bradford City Council by an educational psychologist with the Mental Health Emergency Committee, stated that:

The assumption of responsibility for the child's education by the state has given parents the opportunity to shelve their obligations in individual character training of their children.³⁰

It also maintained that, 'high wages and easy money for the juvenile decreases his respect for property and for privilege.' The social class bias in this depiction is clear, as are the morally authoritarian implications of the view that, 'a considerable proportion of the parents of delinquent children are themselves children in mentality and social consciousness.'³¹ But, in fact, what made this report controversial with city councilors was some of its other assertions.³² For instance, the Bradford report appears to have upset some city councilors by claiming that religious instruction in schools did not lead to lessening delinquency levels. It maintained that, of the 370 delinquent children studied,

²⁹ CGC, 'Juvenile Delinquency and the War: A Critical Survey of Current Comments', *Mental Welfare* 2 No.3 July 1941 66-74.

³⁰ Bradford Education Committee, *Report on Juvenile Delinquency*, (Bradford: Bradford City Council, 1942), p29.

³¹ Bradford Education Committee, *Report on Juvenile Delinquency*, p28 and 29.

³² 'Child Delinquency: Psychologist's Views', *Manchester Guardian*, 22nd February, 1943; 'Causes of Juvenile Delinquency', *Bradford Telegraph and Argus*, 15th February, 1943.

the proportion of those attending church schools was substantially higher than those from council schools.³³ The effects of religious teaching on children's character development and behaviour had not been the subject of 'unbiased investigation', it asserted. The report highlighted the potentially negative effects of attempting to inculcate ideals that were 'far beyond their possibility of achievement, and completely beyond their power of emotional understanding.'³⁴ Morality, it maintained, could only be properly developed through social and relational interaction, and not by the 'passive acceptance of a code superimposed from above'.³⁵ Thus, while it reasserted that the 'natural' role of the family was to inculcate 'civilized' ideals of responsible citizenship, the problematic of understanding and shaping emotions modified this assumption. The direct authoritarian inculcation of moral values could be counter-productive, particularly if it failed to acknowledge important differences in the various stages of emotional development.

An associated issue was the report's assurance that delinquency was a symptom of a lack of emotional security. It contended, in line with mental hygienist's interwar pronouncements, that knowledge of the stages and associated 'needs' of emotional development provided a more scientific means to understand and prevent delinquency. A detailed scientific analysis of each child's case history was necessary. This should include a description of home and school surroundings and a 'detailed personal history of the child's development and his family background.' In addition, it emphasized the need to listen to the child's expression of his or her own views. The delinquent child, it asserted, should be interviewed in a 'neutral' atmosphere without blame where the child's own feelings and attitudes could be detailed. Of central concern was the effect of

³³ Bradford Education Committee, *Report on Juvenile Delinquency*, p27.

³⁴ Bradford Education Committee, *Report on Juvenile Delinquency*, p29. A psychiatric social worker working for the NAMH provided advice to mothers in a similar vein: Cecil Hay-Shaw, *You and Your Child* (London: John Murray, 1949). See the review in *Mental Health* 9 No.1 August 1949, p20.

³⁵ Bradford Education Committee, *Report on Juvenile Delinquency*, p29-30.

emotional attitudes within the family.³⁶ The wider community should also recognize its own responsibility in promoting this emotional security. The report stated that: 'The main thesis put forward is that a punishment for the delinquent act as if he was fundamentally the responsible person concerned is illogical. Responsibility for juvenile delinquency lies with the individual adults concerned with the delinquent, and on society itself...'.³⁷

In all this there are intimations of placing greater emphasis on understanding the details of relationships on the grounds that it was within these that emotional experience was manifest. Morality, stated the Bradford report, could only be developed through social and relational interaction. Similarly 'emotional security' was of the same character and therefore the wider community had a responsibility to contribute to this. The latter was to recognize that social problems such as delinquency were significantly contributed to by the lack of this security. The community thus played a particular role in the creation of delinquency. Emotional security was cast here with an emphasis on its relational phenomena. It was to be understood as produced in an associational matrix with significant others in the family, and also in more general social relationships. The general effect of this way of looking was, in terms of theory, to loosen responsibility for delinquency from something 'fixed' in the individual to relationships with others deemed significant; mother, family, community.³⁸

³⁶ Bradford Education Committee, *Report on Juvenile Delinquency*, p8-9.

³⁷ Bradford Education Committee, *Report on Juvenile Delinquency*, p28.

³⁸ Bradford Education Committee, *Report on Juvenile Delinquency*, p28.

Emotional Relationships and Theorizing on Children's Residential Care.

In March 1945 the government set up the Curtis Committee on the Care of Children Deprived of a Normal Home.³⁹ The Beveridge Report of 1942 had set out guidelines for a National Health Service and a post-war system of social welfare based on social security. Welfare measures for children without homes, however, had not been a major concern of this report. The Curtis Committee was set up partly as a means to consider measures to fill this gap. In 1945, NAMH collated the experiences of its child welfare workers in order to provide evidence for this Committee.

I do not intend to analyse the Curtis Report here, nor the resulting Children Act that followed it.⁴⁰ Instead I want to show how NAMH's criticisms of existing childcare institutions expressed the new primacy placed on engaging with the details of relationships as the locus of emotional experience. There were important consequences to this altered frame of reference. Institutional care was strongly criticized for its general unconcern over the importance of emotional relationships. Accompanying this was an associated censure of the medical model of care, and a prioritization of the perceived need to combat 'unfeeling' attitudes and activities of staff. Significant to all these criticisms was a greater concern to ensure opportunities of choice and freedom in relations as an ingredient of the necessary 'atmosphere' of emotional security. In the following sections I move on to show that these theories of child development and emotional health provided much of the theoretical backdrop to other important sites of mental hygiene intervention and innovation.

³⁹ *Report of the Care of Children Committee (Curtis Report)*; Cmd.6922: HMSO 1946. [1964]

⁴⁰ Though it might be noted that amongst the Curtis Committee's members was Lucy G Fildes, at this time chief educational psychologist to the Provisional National Council.

Conceptualizing the child's emotional experience as at the centre of a matrix of emotional relationships.

Ruth Thomas, the collator and compiler of NAMH's report, made clear the key criteria on which its critique of existing provision was based.⁴¹ The goal of all childcare, she asserted, whether in the family or outside it, was to enable the child to achieve a healthy maturity. This required an analysis of the basic needs of child development. In agreement with the major childcare theorists of the time, NAMH's report conceived that *any* upbringing outside the biological family was necessarily handicapping to the child.⁴² The aim was therefore, particularly with regard to institutional care, to compensate for the loss of the 'natural' family as far as possible, in order to allow the child to take its place in the community as little handicapped as possible.⁴³

In the Bradford report, referred to earlier, there is a perceptible shift from conceptualizing social problems as problems of individual emotional adjustment to considering them in terms of a failure of social integration. This is made distinct in NAMH's criticisms of childcare. Whilst the terminology of 'adjustment' and 'maladjustment' continued to be used the problems that these pointed to were conceived much more in terms of creating the kinds of human relationships that would lead to 'healthy' social integration and combating those that led to social isolation and thus mental disturbance.

⁴¹ Ruth Thomas was the NAMH's chief psychologist.

⁴² Dorothy Burlingham and Anna Freud, *Young Children in Wartime* (London: Allen and Unwin, 1942); Dorothy Burlingham and Anna Freud, *Infants Without Families* (London: Allen and Unwin, 1943); John Bowlby, 'Forty-Four Juvenile Thieves: Their Characters and Home Life', *International Journal of Psychoanalysis* 25 1944 19-53 and 107-128.

⁴³ Ruth Thomas, *Children Without Homes*, p12.

Family relationships were seen to provide the child with a natural way of developing to responsible community life and mental health. Any institutional setting, it was argued, therefore required four general requirements to be met:⁴⁴

- 1) A close and continuous relationship with an adult able to care in such a way as to promote trust and consequent desire to become like the adult.
- 2) A small community life of mixed ages and sexes where family life might be adequately modelled.
- 3) Access to a wider community in which a child may participate.
- 4) Opportunity for freedom and diversity in occupations, possessions and leisure time.

Each of these principles placed emotional sensitivities at the center of understanding mental health and disorder. Moreover, they directed attention to the details of actually existing emotional relationships. Emphasized was, both the delicacy and vulnerability of such relationships, and the consequent requirement for staff themselves to be attuned and sensitive in relation to such factors. At the same time these principles placed overt authority into question as likely to be injurious to emotional stability and development. The fundamental question to be kept in mind Ruth Thomas asserted was '... how does the world of the family, foster home or Home look to the child when he views it from the angle of his needs? In short what does *he* find satisfactory'.⁴⁵ With this prime consideration Ruth Thomas was attesting to the centrality of the personal lived experience of the child. Emotional experience was

⁴⁴ Ruth Thomas, *Children Without Homes*, p24.

⁴⁵ Ruth Thomas; *Children Without Homes*, p11

central to development. This took place in interaction with others, and it required a professional knowledge attuned to its sensitivities. Pre-war child guidance had been 'child centered' in the sense of placing the child at the centre of the problem requiring moral guidance and education. The NAMH directed these considerations to childcare in Homes and institutions. But with their turn to the emotional-relational realm they reconfigured this child-centered approach. By asserting their conceptualization to be new scientific knowledge mental hygienists were contributing to the enshrinement of emotional relationships as essential aspects of personhood. The child's *own* personal relational experience was becoming, in theory at least, central to the measurement of the type and quality of relations that were 'normal' and conducive to 'mentally healthy' development to citizenship.⁴⁶ The resulting recommendations of the NAMH report conjoined the need for sensitivity to children's emotional experience with principles of care that perceived opportunities for freedom and personal choice to be intrinsic aspects of the needs of emotional development.

Criticism of Institutions and the traditional Medical Model of Care.

The negative effects of institutional care were now highlighted through the lens of emotional development. Institutions were condemned as detrimental to child development and mental health when ordered for organizational efficiency and staff interests. Most Public Assistance Homes kept children in a nursery until the age of three and then moved them to a mixed home until the age of seven, with subsequent moves at eleven or fourteen. NAMH censured this system as 'utterly wrong from the point of view

⁴⁶ It is notable that, despite the claimed focus on what the *child* finds satisfactory, the Curtis Committee did not interview a single child from the Homes that they investigated.

of mental health'.⁴⁷ Instead what was now considered essential was continuity of care and a relational environment adjusted to the developmental 'needs' of children. NAMH considered that life for children in large groups promoted gross disturbances of development and mental health. Bed-wetting, anti-social behaviour and emotional disturbance were correlated with large-scale group provision and understood as the precursors of delinquency and mental illness.⁴⁸

NAMH based these views on some of its own experimental residential ventures during the war. At these a 'Group System' was employed, which it was argued should be employed in all children's institutions. Under this system children were divided into groups of four or five of mixed ages and temperaments. Each group was provided with separate living space for play, meals and sleep. A 'Group mother' co-ordinated each group. She provided special outings, clothing and treats as part of her substitute mother role.

Associated with the criticism of prevailing institutional care was a critique of the 'medical model' often employed. Between the wars mental hygienists, such as Hugh Crichton-Miller had criticized general hospital treatment for failing to take into consideration the 'primitive' emotional needs lurking inside their patients which, he argued, was an intrinsic aspect of their particular illness.⁴⁹ With their recommendations for children's residential care, NAMH related these criticisms more closely to the inter-relational realm. Hospital like regimes were considered over-preoccupied with physical hygiene, cleanliness and efficiency. They were also

⁴⁷ Ruth Thomas; *Children Without Homes*, p25.

⁴⁸ Ruth Thomas; *Children Without Homes*, throughout.

⁴⁹ Hugh Crichton-Miller, 'Primitive Man and the Modern Patient', *British Medical Journal* 2 3rd September, 1932 430-432.

correlated with an excessive requirement for order and control.⁵⁰ Such approaches were now considered to distort and deteriorate the emotional relationships upon which children's mental health and development was predicated.

Attention was firmly placed on the nurturing of present emotional relationships as a means to ameliorate adjustment problems and promote healthy development.

Relationships between staff and children were now scrutinized so that staff could be gauged according to the appropriateness of their sensitivity to the dynamics of the children's emotional lives. Staff attitudes and activities now, themselves, came to be more centrally considered as likely causes of children's maladjustment and behavioural difficulties.⁵¹ An emphasis on the emotional experience of the child as a 'living human being' in his or her relational setting entailed a relegation of the traditional medical approach.⁵² In effect care for the upbringing of children in institutions was to be cast in a psychological and therapeutic register. Emotional relationships were central and permeated all aspects of institutional care. The need for affection, emotional security and appropriate relationships was a psychological need that must be taken account of throughout the whole day.⁵³ Comment was also made on the desirability of ensuring that authority was not arbitrary or ill informed. Staff were to be recruited who were 'capable of forming real relationships with the staff and children' in contrast to those who placed an exaggerated importance on their position.⁵⁴

⁵⁰ Ruth Thomas, *Children Without Homes* p48, p59, p61-62.

⁵¹ Ruth Thomas, *Children Without Homes* p113.

⁵² Ruth Thomas, *Children Without Homes*, p12, 45, 59-60.

⁵³ Ruth Thomas, *Children Without Homes*, p41 on nursery care, chapter two for all ages of children.

⁵⁴ Ruth Thomas, *Children Without Homes*, p63 and p82.

Here then is a view of institutional organization and practice as over rigid and unfeeling, creating passivity and emotional isolation. Such a view entailed a greater emphasis upon ensuring that children's freedom of choice and expression should be allowed for and promoted.⁵⁵ Echoing the Bradford report, NAMH's report on child care maintained that: 'Culture is not imposed by lessons or even by a cultivated environment, but by the feelers a child puts out to draw them into himself.'⁵⁶ 'Children, like adults', it remarked elsewhere, 'need to be able to reject or turn down what is offered them.'⁵⁷ Indeed, the report contended that it was only children who had become passively conforming and thus isolated from emotionally secure relationships, who appeared to accept typical institutional life.⁵⁸

A flattening of the Hierarchy of Minds.

The extent to which the perceived unnatural relationships inside children's institutions could affect children's well-being and development was made distinct in the report's discussion of intellectual 'backwardness' and the 'difficult child' in institutions. The recommendations made on the basis of this are important. They reveal that framing mental health and disorder in terms of dynamic emotionality in relationships produced a picture quite different to the hierarchies of mind, and the associated differences in approach to care and therapy, constructed by mental hygienists between the wars. Emphasizing that the term 'backwardness' covered 'both an innate condition' as well as one caused by emotional difficulties, NAMH's report noted that evidence was

⁵⁵ Ruth Thomas, *Children Without Homes*, p39-43, p58, 101-106.

⁵⁶ Ruth Thomas, *Children Without Homes*, p24.

⁵⁷ Ruth Thomas, *Children Without Homes*, p42.

⁵⁸ Ruth Thomas, *Children Without Homes*, p43.

accruing which suggested present care 'may be cultivating the backward child in the unnatural setting of institutional life.'⁵⁹ The report's response to this was to argue that these children's care should be based on their measured mental age and not their chronological age. This was based on the view that their intellectual and moral outlook was equivalent to the former and not the latter. In consequence greater tolerance and understanding of their feelings was recommended. With this NAMH was, in fact, signaling what was to become a growing switch in priorities. The reason for this is not simply that intelligence tests were recognized as only one means to investigate differences in people's personality. What was happening was that looking at emotions in terms of the details of their ebb and flow in relationships had created a new vista in which the similarities in responses of children to their emotional environment became highlighted. These perceived similarities were now – in the case of children termed 'backward' at least – determining the type of care to be provided. Measurements of an internal, and largely fixed intelligence emphasized difference. Differences in gauged intelligence suggested different styles of care. And this was reinforced by an attention to both measured intelligence and emotionality that rested upon a rendition of the past as a progressive evolution of minds and societies. But similarities of emotional responses in relationships suggested similarities of care. What we have here is a breach in the differentiation of therapeutic approach to emotional experience constructed in the hierarchizing of minds that I described in the previous chapter. A determination of these children's mental ages did not render them needful of more direct methods of control and training but, in fact, of *greater* sensitivity and reflexiveness on the part of staff. However, it is important also to note

⁵⁹ Ruth Thomas, *Children Without Homes*, p49-51, quote at p51.

that children considered mentally deficient were not covered by the NAMH report.⁶⁰ The ensuing Curtis Report did not cover their care either. These children's extreme deviation from the statistical norm of measured intelligence, coupled with the notion of their minds as arrested, excluded them from this detailed attention to the effects of emotional relationships. In the following section I look at the quite different conceptualization of care considered appropriate for children and young adults categorized as mentally deficient.

The Impact of Child Care Theorizing On Mental Deficiency.

We have seen in the previous chapter how mental hygienists engagement with emotionality was founded upon progressive histories of individual and social change. This significantly contributed to a theoretical occlusion in the application of the emotional-relational problematic to children categorized as having 'arrested' minds. Mental hygienist's acknowledgement of emotional sensitivity was an acknowledgement to an end; to the construction of emotional 'maturity', adequate socialization, and thus full, responsible, and efficient citizenship. Below a certain defined cognitive and intellectual ability this particular attention to emotional sensitivities was deemed inappropriate. Whilst such a discourse of emotionality placed the margins of classification of mental deficiency into question it did not

⁶⁰ The Provisional National Council report only referred to 'backward' children, whose poverty of experience in children's institutions produced in them the appearance of mental deficiency (p70). The Curtis Committee considered the care of children categorized as mentally defective to be outside their remit. However, it did make brief reference to aspects of their care that had come to its notice. Nevertheless, it did not seek to apply the same principles of care to these children. Comment was made that they required special care and training and it was recommended that 'an immediate census should be taken of ineducable children' in Public Assistance Institutions and Homes, so that the 'earliest possible steps' could be taken to transfer them to 'properly staffed Homes or colonies.' The Committee recommended that no administrative changes should be made regarding these children's care. See *Report of the Care of Children Committee (Curtis Report)*, para 508-510.

question the fundamental division. The psychodynamic underpinnings of this discourse reinforced the effect. An increasing focus on psychological and psychoanalytical theories by mental welfare workers and psychiatric social workers in fact resulted, during the interwar years, in a relative lack of interest in mental deficiency. Associated with this, Child Guidance Clinics, whose services were still expanding, took increasing interest in 'maladjusted' children and there continued a general trend for mentally deficient children to be ignored.⁶¹ Psychoanalysis, in particular, considered mentally deficient children to be constitutionally incapable of the full relational experience required for 'healthy' mental development. Freud himself had maintained that psychoanalysis required 'a certain measure of natural intelligence and ethical development'.⁶² And it is significant that despite the powerful influence of psychoanalytic ideas in child development and adult neuroses in the post second world war period, no major psychoanalytic theorist has focused directly on mental deficiency.⁶³ Mental deficiency, as a testament to arrested development, thus precluded such children from the child-centered approach to emotional relationships advocated for other children.

This distinction between the emotional developmental requirements of normal and 'maladjusted' children, on the one hand and the truncated requirements of mentally deficient children, on the other, was clearly made by NAMH in its wartime proposals for post-war planning of psychiatric child-care. Lucy Fildes, one of its educational psychologists, and chairman of NAMH's *Ad Hoc* Committee on Hostels, stated the opinion of NAMH thus:

⁶¹ Mathew Thomson, *The Problem of Mental*, p289.

⁶² Valerie Sinason; *Mental Handicap and the Human Condition* (London : Free Association Books, 1992, p60.

⁶³ Valerie Sinason; *Mental Handicap and the Human Condition* (London : Free Association Books, 1992, p59-75

'Separate hostels should be provided if possible for the following two groups of children: -

- i) Those constitutionally inferior, whether their inferiority is intellectual or emotional or both.
- ii) The neurotic, i.e. the child of essentially normal personality make-up distorted by environmental circumstances.

This need for separation rests on the fundamental differences in make-up between the two groups of children - those who are by nature inferior, either intellectually or emotionally, need above all things adult guidance and support to a degree above what is considered normal. Neurotic children, on the other hand, require maximum freedom'.⁶⁴

This was a division of emotionality and treatment between 'maladjusted' and mentally deficient children also emphasized by the psychoanalyst D.W. Winnicott. In 1944 Winnicott gave a paper to NAMH's Child Guidance Services Committee on the requirements of hostel provision for 'maladjusted' children. This prompted a written memorandum to the Ministry of Education on the principles on which these hostels should be based.⁶⁵ But Winnicott maintained, however, that mentally deficient children should have separate accommodation and treatment:

This is not only because they need special management and education, but also because they wear out the hostel staff to no purpose, and cause a feeling

⁶⁴ Lucy G Fildes, 'Hostels for Children in need of Psychiatric Attention', *Mental Health* 5 2 (1944) 31-32, p32.

⁶⁵ PNC, *Second Annual Report 1.4.44-31.3.46*, p17 and 27.

of hopelessness. In such difficult work as that with problem children, there must be some hope of reward ...⁶⁶

It is not surprising therefore that the NAMH's recommendations for childcare, developed and outlined during wartime evacuation measures, were not applied to mentally deficient children. NAMH published articles on provision for mentally defective children in their journal *Mental Health* during the war. For example, C H W Tangye, the headmaster of a special school for such children, contributed an article in 1941. In it he remarked that opinions differed over whether the expense and effort of evacuating mentally deficient children was actually worthwhile.⁶⁷ Indeed the only negative effects of the loss of home life that Mr Tangye referred to in his article were those on his staff, evacuated along with the children to set up their schools outside urban areas.⁶⁸ Tangye, however, argued that his experience of evacuating special schools had proved to him the value of 'community life' for mentally deficient children.⁶⁹ But the conceptualization of 'community life' for these children was a very different proposition to that outlined for care of more 'normal' children.

During the preparations for evacuation it was agreed that children designated as mentally deficient should not be billeted with private families but evacuated as a group through the

⁶⁶ D.W. Winnicott, 'Residential Management for Difficult Children', *Human Relations* 1947 reprinted in *Deprivation and Delinquency*, Clare Winnicott, Ray Shepherd and Madeleine Davis (eds) (London: Tavistock, 1984) 54-72, p65.

⁶⁷ C H W Tangye, 'Some Observations of the Effect of Evacuation Upon Mentally Defective Children', *Mental Health* 2, No. 3 July 1941 75-78, p75. Mr Tangye was Head Master of Lewisham Bridge L.C.C. Elder Boys (M.D.) School. In April 1940 he was a speaker at a one day conference of the Association of Mental Health Workers (one of the constituent members of the Mental Health Emergency Committee) dedicated to 'Evacuation and Mental Health Work', *Mental Health* 1. No. 2. p61.

⁶⁸ C H W Tangye, 'Some Observations of the Effect of Evacuation', p75.

⁶⁹ C H W Tangye, 'Some Observations of the Effect of Evacuation', p78.

setting up of Residential Schools in evacuation areas.⁷⁰ Emphasis in these residential schools was on control and discipline. The headmaster of one special school evacuated to One Oak, Ilkley, emphasised the gains in physical health, educational standard and general conduct that ensued at the evacuated school. He claimed that much of this change was due to the greater regularity and control of life which segregated residential care in the countryside entailed. Separation from the perceived detrimental effects of home conditions was seen as beneficial, as was the increased opportunity to apply one central authority of 'control' in a residential school separate from home and family.⁷¹ Much effort was put into correcting bad habits seen as consequent of poor or indulgent home training and outlook.

Attitudes towards bedwetting illuminate the gulf between approaches advocated for 'normal' and 'difficult' children in comparison to those who were mentally deficient. In its memorandum of evidence to the Curtis Committee, NAMH maintained that,

...the homeless child is particularly susceptible to [bedwetting] because of the emotional deprivations he suffers. ... It is often a form of aggressive behaviour – the child's way of registering protests when conditions make him unhappy. In almost all cases, however, it is a form of behaviour which is beyond the child's power to control consciously and can be dealt with successfully only where it is possible to get some insight into the deprivations from which he suffers and against which he is unwittingly protesting. Punishment in all cases is liable to exaggerate the difficulty and add other forms of adverse behaviour.⁷²

⁷⁰ H. Barker; 'A Special School Evacuation Unit: Some Observations on its Value', *Mental Health* Vol 3, no. 2, Summer 1942, 37-39, p37

⁷¹ H. Barker; 'A Special School', p38.

⁷² Ruth Thomas; *Children Without Homes*, p51-2.

These principles were not applied to mentally deficient children. In July 1941 NAMH printed W A G Francis' record of enuresis at his evacuated special school for mentally deficient children. Bedwetting, he explained, had quickly become a frequent occurrence at the evacuated school. The method devised for dealing with it was based on praise and punishment. Children who had wet their beds were referred to as 'offenders' who were sent to the 'Camp Commandant' to be recorded and censured. Out of a total of 216 boys living at the camp about 140 boys had appeared on the register. This system, he argued, successfully trained the large majority of children in 'good personal habits'.⁷³

Children diagnosed mentally deficient thus continued to lack the 'right' to the kind of environment and emotional engagement that mental hygienists now deemed essential for other children. The mental hygiene attention to emotionality had concentrated on posited stages of infant and child development but its theoretical foundations blinkered it to mentally deficient children. However, whilst largely ignoring mentally deficient children, the fundamentals of this discourse of emotionality, now situated in the relational milieu, can be seen to have informed mental hygienists' pioneering therapies with 'maladjusted' and mentally ill adults. In the following section I show how these elements can be found at three sites of intervention.

⁷³ W.A.G. Francis, 'Enuresis Record', *Mental Health*, Vol 2, no. 3, July 1941, p78

Engagement with Emotional Relationships: Experimental Approaches at Northfield Therapeutic Community, the Civil Resettlement Scheme and the Social After-Care Service.

In the final section of this chapter I want to elaborate some of the clear continuities between other wartime experimental schemes associated with mental hygiene and the child care theories I have just outlined. Analysing mental hygiene in terms of its problematic reveals this.

Of the three approaches I shall discuss, the therapeutic community concept is perhaps the most distinct and forthright expression of conceptualizing mental health and disorder in terms of emotional relationships. With this in mind it is worth noting that historians have not done well by therapeutic communities. Two popular and relatively recent broad ranging works dismiss their impact and influence.⁷⁴ In the opinion of Edward Shorter, such communities represented simply one aspect of the eclectic approach of psychiatry; an approach born of desperation and rendered unnecessary by the 'neurobiological revolution' of the latter decades of the twentieth century.⁷⁵ For Ben Shephard, the therapeutic communities developed in the 1940s and 50s were pampered experiments with, debatable results, marginal impact, and little long-term influence.⁷⁶

But the therapeutic community experiments are actually very important because they reveal clearly, not only the shifted frame of reference that I describe, but also some of

⁷⁴ Edward Shorter, *A History of Psychiatry: From The Era of The Asylum to the Age of Prozac* (New York: John Wiley and Sons, 1997). Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists 1914-1994* (London: Jonathan Cape, 2000).

⁷⁵ Edward Shorter, *A History of Psychiatry*, p238.

⁷⁶ Ben Shephard, *A War of Nerves*, p268 and p335.

the important consequences of this shift. There are, in any case, obvious reasons why Shorter and Shephard dismiss the importance of therapeutic communities for the history of twentieth-century psychiatry. For his part, Shorter claims to provide a history of psychiatry free of 'sectarianism' and the imprint of ideology.⁷⁷ This would be a unique achievement if it were remotely possible. Unfortunately it is not. And, as is usually the case with those who claim to such, Shorter provides an argument that is all the more bluntly ideological for his apparent assumption that he has stripped away ideology to bear the kernel of truth about both mental disorders and the past as it relates to them. Shorter's is a reductionist account of mental problems that claims to show the ultimate success of genetics and the biology of the brain. He states from the outset that 'history' has already revealed psychoanalysis to be, just like Marxism, another 'dinosaur ideology'.⁷⁸ Given this and Shorter's claims to strip history free of the bias of ideology it is not surprising therefore that he relegates psychoanalysis, and therapeutic communities (of which he acknowledges psychodynamic approaches played a fundamental part) to the status of redundant and misguided alternatives.⁷⁹ In the case of Shephard, his discussion of therapeutic communities is in terms of a history of the twentieth century engagement of psychiatry with the military. Shephard's is very much a masculinist history that sustains a view of emotionality as weakness. In essence his book asks the question: Which therapies were the best at stopping soldiers from breaking down or malingering? Given that sort of question it is not surprising that Shephard doesn't judge favourably any sort of treatment that smacks of pandering to a soldiers vulnerabilities and emotions. Therapeutic communities can easily be regarded as doing that.

⁷⁷ Edward Shorter, *A History of Psychiatry*, pviii.

⁷⁸ Edward Shorter, *A History of Psychiatry*, pvii.

⁷⁹ Edward Shorter, *A History of Psychiatry*, chapters five and six.

But there are other, more sophisticated, conceptualizations of the historical importance of therapeutic communities that are more pertinent to my argument here. Nikolas Rose has incorporated them into his strong constructionist description of how the psy disciplines have played a preeminent role in creating the modern 'self'. Rose, along with Peter Miller, associates them with the social extension of the psychiatric system through the second half of the twentieth century, and argues that they were linked to a transformation in the regulation of mental life. They were thus a part of a psychiatric strategy that promoted 'socially competent and trouble free psyches' in the interests of 'institutional efficiency, social tranquility and personal happiness.'⁸⁰ There is certainly some truth in this. Looked at in terms of the application of a problematic of moral therapy for the community of individuals – whether in an institution or at large – the normative injunctions are clear. Indeed, perhaps the most obvious continuity with concurrent childcare theorizing by mental hygienists is the conjoining of a recognition of the subtleties and sensitivities of emotional relationships with an attempt to normalize people for social efficiency. One psychologist involved, for example, saw his role as 'to produce self-respecting men socially adjusted to the community and therefore willing to accept its responsibilities whether in peace or war'.⁸¹ This notion of social responsibility to the community was an inherent and inescapable aspect of a therapy applied at a military establishment in wartime. But, the requirement, in childcare theory, to emulate the 'correct' social ideal was preserved at the therapeutic community experiments. There continued an inherent belief in the need for the development of 'adjustment' to 'social responsibility' and the values of the 'community'. Implicit in this was the assumption that these values of the community existed in 'fact' and could be mediated to the patients by doctors. One psychiatrist at

⁸⁰ Peter Miller, and Nikolas Rose, 'Introduction' to Peter Miller and Nikolas Rose, (eds) *The Power of Psychiatry* (Cambridge: Polity Press, 1986), p5.

⁸¹ W.R. Bion, *Experiences in Groups* (London: Tavistock, 1961), p13.

Northfield maintained, the aim of hospital treatment remained the re-socialization of the patient and the modification of 'emotional drives' in order to fit in with the 'demands of real life'.⁸² Another used military analogies in his therapy to emphasize that the men were soldiers.⁸³ This surely begs the question of what the demands of 'real life' actually are, and which of them should, indeed, be adjusted to. War against fascism or not, the necessity of fighting wars must remain questionable as an aspect of 'real life' which must be 'adjusted' to in the name of mental health. If mental health really were to be located in the ebb and flow of ongoing emotional relationships, could this 'health' be maintained through the experience of war? Such incongruities appear to have been unconsidered, and indeed, remain noticeably unquestioned in recent literature on these wartime therapeutic communities.⁸⁴

However, Rose and Miller have their attention firmly focused on an unremitting and ever broadening 'power of psychiatry' and its ongoing construction of our very 'souls'. As I have noted they perceive emotionality only in terms of a subjective economy that is formed and shaped by intellectual knowledge and practice. I criticize this approach in detail in my final chapter. But for the moment I want to emphasize the specific point that such a conceptualization of subjectivity and emotionality appears to preclude any notion that subjective experience and emotionality can provide any sort of counter-power. According to these strong constructionists there is only an unremitting and remorseless construction of 'the self'. And, because they hitch this

⁸² T.F. Main, 'The Hospital as a Therapeutic Institution', *Bulletin of the Meninger Clinic* 10 No.3 May, 1946, 66-70, p 66.

⁸³ W.R. Bion, 'The Leaderless Group', *Bulletin of the Meninger Clinic* 10 No.3 May, 1946, 77-81; Tom Harrison, 'Battle fields, social fields, and Northfield', *Therapeutic Communities* 17 3 (1996) 145-148, p146.

⁸⁴ For example; Penelope Campling and Rex Haigh (eds), *Therapeutic Communities: Past, Present and Future*, (London: Jessica Kingsley, 1999); R. D. Hinshelwood, *Thinking About Institutions: Milieux and Madness*, (London: Jessica Kingsley, 2001).

description of power to the apparently preeminent power of medicine and psychiatry in the twentieth-century, they cannot conceive anything other than a remorseless extension of psychiatric power that constructs 'the self'. With this strong constructionist theorizing we have reached the point where no other appreciation of power can be accepted. Power is that which conceptualizes, acts upon, and therefore constructs 'reality'. That is all. These theorists cannot comprehend subjective experience and emotionality having any counter-effect on this power of psychiatry that they describe. I take a different view. Instead of showing what the power of psychiatry has done for subjective and emotional experience, I intend to describe what paying attention to the relational dynamics of emotionality did to the power of psychiatry.

The Three Experiments Briefly Outlined.

Wartime provided the means for influential advocates of mental hygiene to promote their cause. Measurement of 'usefulness' to the community, through methods of selection and testing, and attempts to prevent the 'social problem' of mental problems in society, were transplanted and applied to military life. 'The requisites of sound mental hygiene', wrote the psychiatrist Kenneth Soddy soon after the war, are, 'belief in the justice of the cause; belief in the soundness of the higher leadership; efficient primary selection to exclude the unfit; planned placing of men in roles for which they are suited; efficient training methods and the inculcation of group feeling; careful skilled and considerate officers; planned indoctrination and up to date dissemination of information.'⁸⁵ These had been the, often voiced, goals of mental hygienists

⁸⁵ Kenneth Soddy, *Some Lessons of Wartime Psychiatry* (London: NAMH, 1946), p3-4.

between the wars. J R Rees, at that time medical director of the Tavistock, was appointed head of the Directorate of Army psychiatry in 1941.⁸⁶ He and his team of so-called 'Tavi Brigadiers' used the new perspectives of social psychology and interpersonal relations to approach the large-scale management and organisational problems of the army.⁸⁷ There was thus a pre-occupation with large-scale group and social phenomena. The main areas of focus of the Directorate of Army psychiatry were selection and testing, training and management, morale, resettlement, readjustment of traumatised soldiers and prisoners of war and psychological warfare.⁸⁸

The notion of a therapeutic community within hospital was one of the concepts developed by the application of analyses of human relations to soldiers' morale. From 1942 onwards, methods of treatment were developed for servicemen diagnosed psychoneurotic at military hospitals. One of the most important of these was Northfield Military Hospital near Birmingham. The nature of the experiments that took place here were no doubt, in part, determined by military administration and the need to deal quickly and efficiently with large numbers of patients. Nevertheless, psychiatrists deliberately exploited such situations in order to develop therapeutic systems of group relations based on social psychology and the object relations school of psychoanalysis. The psychoanalyst John Rickman considered this work to be 'one of the biggest, costliest experiments in psychodynamics now running'.⁸⁹ As early as 1939, he and the psychologist Wilfred Bion, had set out some of the procedures that

⁸⁶ J.R. Rees had been a psychiatric consultant to the army since 1939

⁸⁷ Henry V. Dicks; *Fifty Years*, p5

⁸⁸ Henry V. Dicks; *Fifty Years*, p5-6 and Peter Miller and Nikolas Rose; *The Tavistock Programme*, p179

⁸⁹ J. Rickman, letter to S.H. Foulkes cited in Tom Harrison, 'Battle fields, social fields, and Northfield', *Therapeutic Communities* 17 3 (1996) 145-148, p146.

would later be operated at Northfield. They outlined a plan for encouraging soldiers to resume social contacts. There followed another paper in 1941 that detailed methods of group therapy that could be used.⁹⁰ Rickman and Bion's subsequent experiment at Northfield was short lived but another swiftly followed it, this time led by the psychiatrists Tom Main and S.H. Foulkes.

The Civil Resettlement Scheme (CRS) was set up as an experiment in helping repatriated soldiers. This work originated from wartime attempts to understand the psychological difficulties of officers who had escaped from prisoner of war camps. The aim was to rehabilitate them to military service.⁹¹ By January 1946 the CRS comprised twenty regional resettlement units intended to help both officers and men re-adjust to civilian life. Participation was entirely voluntary and the aim was now to combat the isolation, frustration and mistrust considered to be the main problems of expatriates.⁹²

Mental hygienists developed the Social After-Care Service (SACS) during the latter years of the Second World War. This attempted to provide a form of psychiatric rehabilitation service in the community. Mental hygienists developed, and promoted the scheme, from the outset as a potential framework for the promotion of mental adjustment in the community. The scheme began operation in January 1944 and was

⁹⁰ These plans subsequently became known respectively as the 'The Haymeads' and the 'Wharnccliffe' Memorandums. See, John Rickman, *Haymeads Memorandum* Rickman Archive of the British Psychoanalytic Society; London. Cited in Harrison, Tom, 'Battle fields, social fields, and Northfield', *Therapeutic Communities* 17 3 (1996) 145-148, p146. On the 'Wharnccliffe' Memorandum, Gerard Bleandonu, *Wilfrid Bion: His Life and Works 1897-1979* (London: Free Association Books, 1994), p54-5. Also, Pines, Malcolm, 'Forgotten Pioneers: The Unwritten History of the Therapeutic Community Movement', *Therapeutic Communities* 20 1 (1999), 23-42, p32-33.

⁹¹ Bootle-Wilbraham, 'Civil Resettlement of Ex-Prisoners of War', *Mental Health* 6 No.2 July 1946 39-42, p39.

⁹² A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', *Lancet* 1 31st May, 1947 735-738, p735.

designed to help with the 'social adjustment' of men and women discharged from the services for psychiatric reasons. NAMH operated the SACS, under the general supervision of the Board of Control, and with the involvement of the three armed services and the Ministries of Pensions, Labour and Health.⁹³ The scheme applied to a selected group of thirty service psychiatric hospitals and E.M.S. Neuroses Centres. A Services After-Care Officer interviewed patients before discharge where it was thought that they would benefit from after-care. The patients' plans and problems would be discussed at this interview. The Officer would make a report, which included the recommendations of the medical officer and this was sent, via the Board of Control, to one of NAMH's Regional After-Care Officers operating in the patients' home area. These officers were psychiatric social workers who visited the discharged patient at home in order to help with satisfactory adjustment to civilian life. NAMH envisaged their work as helping to link and coordinate relevant local social and medical services, at the same time as providing a 'friend and adviser to the patient'.⁹⁴ About 1,500 people were seen under the service in the first six months of its operation. By the end of 1946 the number had risen to 10,000.⁹⁵ The latter figure included civilians who, from 1946, were also permitted to receive casework under the scheme. Despite the extremely limited numbers of available personnel, this was the first time that a community service had been provided on a national scale for the after-care and support of people with psychiatric problems.

⁹³ 'News and Notes', *Mental Health* 5 1 (1944) p12-13.

⁹⁴ 'News and Notes', *Mental Health* 5 1 (1944) p13.

⁹⁵ E.M. Goldberg, 'The Psychiatric Social Worker in the Community', *British Journal of Psychiatric Social Work* 4 2 (1957) 4-15 p4.

Relational therapy for maladjustments understood as failures of relationships.

As we have seen, mental hygienists' proposals for residential childcare placed the relational dynamics of care as central to emotional development and mental health. Similarly, the central conceptual foundation of Northfield, the CRS, and SACS was that the mental disorders and maladjustments that they sought to treat were distinguished by an inability to form and maintain satisfactory inter-personal relationships. Bion and Rickman argued that their work at Northfield had proved the need for more detailed analysis of the structure and 'interplay of forces' within groups. Psychology and psychopathology had focused too much attention on the individual, they argued, to the exclusion of the social field.⁹⁶ Similarly Main contended that not only was 'radical individual psychotherapy' simply impractical to deal with the 'huge numbers of patients confronting our work today', but that, individual treatment was, by its nature incomplete. Individual treatment could free the inner drives of a patient and thus provide the basic capability for a return to social life. But, for Main, his patients suffered from a disturbance of relationships and therefore required a 'framework of social reality' which could enable better social insight and an environment within which emotional drives could be modified to the demands of social life.⁹⁷

The same conceptualization was expressed in the operation of the SACS. The philosophy that informed this service was described by NAMH in a memorandum prepared for the Ministry of Health Younghusband Committee on Social Workers in the mid-1950's. This memo reiterated the SACS wartime recommendations that

⁹⁶ W.R. Bion, and J. Rickman, 'Intra-group tensions in therapy: their study as the task of the group', *Lancet* 2 151 678-681.

⁹⁷ T.F. Main, 'The Hospital as a Therapeutic Institution', p66.

adequate emotional relationships in infancy and childhood were of fundamental importance for mental health. Also that community mental health could exist only when these primary conditions were met. The SACS saw its role as attempting to ameliorate 'unsatisfactory relationships' that nevertheless endured, or became manifest, in adulthood.⁹⁸ The key to the living patient's experience, it was maintained, lay in their relationships.

The CRS also held this conceptualization. The aim was to facilitate the resettlement of military personnel into civilian life by helping them to re-make adequate inter-personal relationships. Discussing this process at the CRU, the psychiatrist A.T.M. Wilson agreed with Bion and Rickman's contention, based on their work at Northfield, that; '...passive non-cooperation with one's community is a painful state from which we emerge with relief, given adequate opportunity.'⁹⁹ He went on to cite Main's work at Northfield as providing one form of community that could facilitate this change.

Mental hygienists' wartime description of childhood emotional development as requiring 'emotionally secure' relationships, appropriate to each stage of progressively widening inter-personal relations, was reiterated in the context of adult therapy at the wartime schemes. Under the SACS casework was conceptualized in terms of mirroring a 'mature' 'mothering' relationship that would allow the development of emotional security and progression through stages of sociability and responsibility.¹⁰⁰ At the CRS repatriates experiencing difficulties in resettlement were considered to be

⁹⁸ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', 5th October 1956, para 11 and 19-20.

⁹⁹ A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', p736.

¹⁰⁰ E.M. Goldberg, 'The Psychiatric Social Worker in the Community', 12-13.

revealing a deeper inner need for 'security and affectionate relationships'.¹⁰¹ It was claimed that separation from their homes and communities had created acute feelings of isolation, frustration and distrust of authority. This, it was argued, often took the form of an 'embittered withdrawal from social relationships'. The task of the CRS was to counter this suspicion of authority, facilitate a return to a 'less regressed social attitude in the unit' and then wider re-relation with family and community.¹⁰² Similarly, at Northfield, Main described patients' progression through, what he called the 'various therapeutic social fields created in the hospital.' What was aimed for was a growth in sociability, from regressed and isolated states, through small groups of interaction, ultimately to full social relationships outside hospital.¹⁰³

Freedom, and Choice as essential elements of the right emotional requirements for therapy.

There is another associated and significant element to this. The concept of being a voluntary patient was cast in a new role here. (We will see that this feeds into later civil rights activity). As we have seen, interwar, mental hygienists had pressed for legislation so that patients could be accepted into mental hospitals as voluntary admissions rather than certified. They had argued that the prevailing system of certification created stigma and mitigated against the early treatment of mental disorders, the very time at which psychiatrists held most hope of a successful outcome. The 1930 Mental Treatment Act partially provided for this. But, as we

¹⁰¹ A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', p738.

¹⁰² A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', p735-737. Quotes at p737 and 736 respectively.

¹⁰³ T. F. Main, 'The Hospital as a Therapeutic Institution', p69-70.

have seen, mental hygienists conceptualized voluntary treatment as a public health measure. It had been promoted in terms of the mental health of the community as much as that of the individual. Voluntary treatment was conceived as a matter of submitting oneself to hospital in the interests of treatment, not as a matter of patients themselves being able to determine when and whether to leave hospitals in their own interests.

The emphasis placed on quality of emotional interaction, at the wartime experiments, modified this. Just as the concepts of freedom and personal choice were highlighted for childcare, so they were also emphasized as important elements of the SACS. Participation was entirely voluntary.¹⁰⁴ The NAMH contended that:

The principle of freedom of choice is very important in social work, and an individual must be allowed to decide for himself whether he wishes to consult a social worker. There must be freedom to refuse as well as accept help, and the fullest benefit from social casework will only be obtained by a client who volunteers his co-operation. ...the success of the NAMH after-care scheme was bound up with the application of this principle.¹⁰⁵

In part this can be seen as a continuation of the concept of voluntary treatment promoted by mental hygienists between the wars. It was certainly a means to encourage early treatment. But the SACS emphasis, similarly to the wartime child care theorizing, was less on using the voluntary concept in order to encourage

¹⁰⁴ Kenneth Soddy, 'Community Care of Psychiatric Patients – A Review', Appendix to NAMH and APSW, *Memorandum on Rehabilitation of Psychiatric Patients: Evidence to the Committee of Enquiry into Existing Services for the Rehabilitation of the Disabled*, February 1954, p1.

¹⁰⁵ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', para 56.

submission to treatment as a socially responsible public health measure, than as an aspect of therapy itself. The old one-way reason of moral therapy that had originally been employed by mental hygienists was undermined with the shift of problematic to locating mental troubles in emotional relationships. What was important here was that a relationship should be built up between social worker and client in which the latter could feel secure. Only in this way could a relationship of confidence develop in which therapy could take place.¹⁰⁶ It followed that a continuity of relationship with one social worker should be aimed for. In its post war theorizing, based on experience gained operating the SACS, NAMH maintained that where possible choice of social worker should be left to the client.¹⁰⁷ These principles are directly similar to those proposed for residential childcare. What was required was a continuity of personal relationship and an emotionally secure relational environment in which trust could be developed. These and an emphasis on freedom and choice were to be the elements of the therapeutic relationship.

At Northfield, and the CRS, therapy was an ongoing part of the whole day and patients were to be free to enter into it or not. Yet again there are similarities with the attention to emotional relationships in childcare. The NAMH report on child care contended that children's transition through delicate stages of emotional development and the relational matrix in which this took place, required that they be allowed greater freedom to enter into or reject activities according to their needs. Children needed to grow through widening stages of sociability at the pace of their own emotional needs. At the CRS, freedom and choice over when and how to enter

¹⁰⁶ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', para 27.

¹⁰⁷ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', para 57.

therapeutic situations were considered an intrinsic aspect of re-socialization.¹⁰⁸

Freedom and choice were not simply the aims, but now also the means, of therapy.

At Northfield, Main held to the same approach. Patients were to be 'free to move at their own choice and at their own speed within the social fields which best suited them.'¹⁰⁹

Criticism of Institutions and the traditional Medical Model of Care.

NAMH's recommendations on residential childcare had offered an image of the prevailing order of institutions as detrimental to mental health and development. Rigid discipline and relations built around organizational hierarchy were correlated with children's isolation and passivity, and condemned as inimical to healthy emotional relationships. Associated with this, the medical model of care was criticized as too concerned with hygiene, order and control. Similar contentions were made at Northfield. Tom Main maintained that mental hospitals encapsulated in their practice the 'traditional mixture of charity and discipline', and 'a practiced technique for removing [patients] initiative as human beings'. He argued that hospitals were operated as organizations promoting their own technical and organizational efficiency. In such circumstances patients who were dependent, conforming and passive were considered 'good' patients by staff.¹¹⁰ With a central component of mental disorder now considered to be an inability to relate, hospitals were revealed as, in fact, detrimental to health. On the basis of the perceived need to re-institute

¹⁰⁸ A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', p736; Brigadier L. Bootle-Wilbraham, 'Civil Resettlement of Ex-Prisoners of War', p40.

¹⁰⁹ T. F. Main, 'The Hospital as a Therapeutic Institution', p70.

¹¹⁰ T. F. Main, 'The Hospital as a Therapeutic Institution', p66.

healthy relationships Main argued that the hospital should be reorganized. It should not dominate and isolate patients through its bureaucratic and treatment regime, but seek to provide the social support and opportunities provided in 'spontaneous and emotionally structured' communities.¹¹¹ In an analogous fashion the CRS contrasted its open and relatively egalitarian approach with the rigid discipline of the army. Indeed the CRS openly characterized itself, in contrast to the 'paternal and authoritarian' military, as a 'maternal and democratically conceived community'.¹¹²

An associated, though more muted, move away from traditional institutional care was expressed through the operation of the SACS. The psychiatrist Kenneth Soddy (by 1946 the Medical Director to NAMH) wrote that the situation of psychiatric social workers in this scheme was analogous to that of army Area Psychiatrists during the war. 'The latter', he noted, 'found that their main attention inevitably became attracted to attacking social and psychological causes rather than attempting patchwork on individuals'.¹¹³ Soddy maintained, along with other mental hygienists, that a comprehensive service for mental health should be organized around a social service in the community rather than the clinic or hospital.¹¹⁴ After the war NAMH remarked, in reference to the SACS, that a training in nursing was not a preparation for social casework, and that 'a health approach' was not always an advantage in psychiatric social casework.¹¹⁵

¹¹¹ T. F. Main, 'The Hospital as a Therapeutic Institution', p67.

¹¹² A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', p736.

¹¹³ Soddy, Kenneth, 'Some Lessons of Wartime Psychiatry', *Mental Health* 6 3 (1946) 66-70, p68.

¹¹⁴ Soddy, Kenneth, 'Some Lessons of Wartime Psychiatry', 66-70, p68.

¹¹⁵ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', para 64.

A flattening of the Hierarchy of minds.

At the wartime schemes there is no direct corollary of the reconceptualization of the care of children with low measurements of intelligence (termed 'backward') as in NAMH's advice on residential childcare. However there are associated developments that suggest a lessening of the categorization and differentiation between minds that had been deployed by mental hygienists in the decades before the war.

At the SACS the caseworker's role, it was argued, was not to be the 'authoritarian one of giving advice'.¹¹⁶ NAMH maintained that:

The caseworker will not only refrain from imposing her will but will also avoid imposing moral values on an individual. Even when the client acts in a way which seems contrary to his own interests, the caseworker will still strive to be objective, neither condemning nor condoning but respecting the right of individuals to hold their own standards and beliefs.¹¹⁷

This statement is, nevertheless, not as clear-cut and universal as it appears. A NAMH report on the SACS, for example, noted that the civilian intake for the service was evenly distributed amongst the social classes except for the lowest income group. It went on to remark that this showed the need of other provision to be made for this 'social problem' group.¹¹⁸ Despite this, and indeed, despite the question of whether it was ultimately possible in any case to avoid imposing moral values, the SACS nevertheless, represented the shifted understanding of freedom and therapy. Freedom

¹¹⁶ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', para 24.

¹¹⁷ NAMH, 'Memorandum Prepared for the Working Party on Social Workers', para26.

¹¹⁸ Kenneth Soddy, 'Community Care of Psychiatric Patients – A Review', p2.

of choice and active co-operation were held to coincide as reciprocal and integral components of both, normal healthy relationships, and therapeutic ones. Just as with wartime child care principles propounded by mental hygienists, freedom, personal choice, continuity of individual care, and emotional security were considered central and related aspects of the therapeutic milieu.

These principles were not limited to people deemed largely recovered from mental illness or suffering from minor mental troubles in the community. Thirty percent of the people receiving assistance were described as suffering from psychoses.¹¹⁹ The NAMH noted that this suggested that 'social supervision of recovering and chronic psychotic patients is a valuable social therapeutic instrument.' Indeed NAMH emphasized that such people were widely regarded by social workers operating the scheme as suitable for care in the community, and that 'a diagnosis of insanity' need not now be considered 'tantamount to an order requiring incarceration.'¹²⁰ It also noted that the large numbers of such people suggested that the public could accept the notion of people diagnosed psychotic receiving care while living in the community.¹²¹ The NAMH's conclusions were further reinforced by the fact that over fifty percent of people diagnosed psychotic were, in fact, gainfully employed.¹²²

At Northfield, the CRS, and to a certain extent the SACS, all activity was in theory, arranged around the continuous inter-play of emotionality. This was in continuity

¹¹⁹ Kenneth Soddy, 'Community Care of Psychiatric Patients – A Review', p3. This percentage remained constant after civilians were incorporated into the scheme. Over sixty percent of people diagnosed as neurotic were employed. The percentage of those unemployed was given as thirty-five percent of those whose circumstances were known but these included housewives, children and students.

¹²⁰ Kenneth Soddy, 'Community Care of Psychiatric Patients – A Review', p3 and p4-5.

¹²¹ Kenneth Soddy, 'Community Care of Psychiatric Patients – A Review', p8.

¹²² Kenneth Soddy, 'Community Care of Psychiatric Patients – A Review', p5.

with NAMH's residential childcare philosophy. As we have seen this expressed the view that children's emotional needs should be engaged with throughout the whole day. A notable aspect of this is that *within* these treatment areas the hierarchies of minds and the concomitant differential treatment of emotionality was flattened. Tom Main, for instance, described the commonly existing mental hospital as authoritarian and hierarchical, with a rigid organization designed for discipline.¹²³ In his view the proper therapeutic environment should be 'spontaneous and emotionally structured (rather than medically dictated)'. For Main, there was not simply an administrative need for discipline and containment, but also an emotional one on the part of the staff. This 'need', coupled with a desire for gratitude from the patient, was considered conducive only to mental ill health. Main emphasized the need for staff to confront their own emotional needs and conduct. Participation with patients' in group therapeutic sessions was considered necessary, both to understand the effects of staff inter-relations, and also to encourage full community integration. This questioning of staff attitudes and conduct on the same therapeutic basis as that directed to patients expresses the most radical aspect of therapeutic community approaches as they came to be developed. They represent a similar, but more forthright, application of the emotional-relational problematic employed in residential childcare theorizing. Although, as we have seen, these themes of staff reflexivity were apparent in the latter they remained relatively un-developed at this time.

Nevertheless, at Northfield, the CRS, the SACS, and in residential childcare theorizing, hierarchy and authority were to be flattened in the interests of more direct emotional engagement. As Main put it, the doctor was no longer to trade his

¹²³ Main, T.F., 'The Hospital as a Therapeutic Institution', *Bulletin of the Meninger Clinic* 10 1946, p66.

'anarchical rights' of detached authority and the 'right to pass judgement'.¹²⁴ Foulkes and his colleague E.J. Anthony later described the shift of approach in this way:

The eye at work, although a psycho-analytic eye, declines to see the new phenomenon from behind the analytic couch. Instead it places itself in the circle, eye to eye with other members, a *participant observer*. It could only be regarded as a revolutionary therapeutic event when the therapist forsook his sheltered position behind the desk, the couch, the white coat, the stethoscope, and came out 'into the open' on a level with his patients.¹²⁵

This was an image paralleled in a description of the psychiatrist's role at the CRS. Here it was emphasized that the psychiatrist adopted a reserved and background role in group therapy discussions. It went on: 'But this is not to say that the psychiatrist removes himself from the picture; on the contrary, he is a *member*, as well as being an observer, of the group.'¹²⁶ In terms of mental hygiene and the extension of the moral therapy frame of reference, what was happening was that the therapist was stepping into the picture. Or, rather, coming to recognize that this was unavoidable.

¹²⁴ Main, T.F., 'The Hospital as a Therapeutic Institution', p67-68.

¹²⁵ Foulkes, S.H. and Anthony, E.J; *Group Psychotherapy: The Psychoanalytic Approach: Patients and students join in a common quest for the solution of mental and emotional problems* (Harmondsworth: Penguin, 1957), p29 (italics in the original).

¹²⁶ A.T.M. Wilson, Martin Doyle and John Kelnar, 'Group Techniques in a Transitional Community', p737.

Chapter Four.

Emotions Situated in the Web of Relationships: 2.

Introduction.

In the first section of this chapter I want to look at how mental hygienists deployed their emotional-relational problematic at the programmatic level. I concentrate mainly on the International Congress on Mental Hygiene held in London in 1948 under the auspices of NAMH. I show how mental hygienists continued to base their authority on the delineation of particular stages of social and individual development. This discourse was primarily centered on an outline of emotional development to 'maturity'. Co-existing histories of development, based upon constitutional and hereditarian notions, were largely relegated from attention. Mental deficiency, as a 'social problem' was largely ignored. Mental hygienists primarily concerned themselves with the creation of a functionalist social harmony and the key to this now appeared to lie with the rest of the population. The second section of this chapter shows how their fundamental attention to emotional relationships nevertheless opened a theoretical space that revealed some of the power relationships inherent in mental hygiene itself. In this context I discuss the National Council for Civil Liberties' campaign against the operation of the mental deficiency system. The NCCL employed and promoted the new psychological thinking to buttress their calls for change. In so doing the one-way authority of mental hygienists was questioned, and they were portrayed as participants within the 'social problem of mental deficiency' that they had isolated and claimed to be able to resolve.

The International Congress on Mental Health

Mental hygienists were quick to make use of wartime experiences in order to reinforce their appeals for the necessity of comprehensive preventive psychiatric services for the nation. In 1945 J R Rees published *The Shaping of Psychiatry by War*. This book took the techniques and approaches of the Directorate of Army Psychiatry and applied them to social and mental health issues in wider post-war society.¹ The following year, the eugenicist C.P.Blacker, published his report on neurosis and the mental health services.² Both works sought to promote a future post-war psychiatric service concentrating on preventive measures and early intervention. Mental disorders would be prevented through early detection and treatment while mental health would be promoted by psychiatric and psychological selection measures designed to enable the 'best fit' of aptitude and personality with education and employment.

The ambitious aspirations of mental hygienists were well represented by preparations, immediately following the war, to organize a Third International Congress on Mental Hygiene.³ Plans for this Congress had begun as early as 1945.⁴ J.R. Rees was a leading instigator of its formation. Rees had made close contact with U.S.

¹J. R. Rees, *The Shaping of Psychiatry by War* (Chapman and Hall Ltd, 1945).

²C.P.Blacker, *Neurosis and the Mental Health Services* (London: Humphrey Milford/Oxford University Press, 1946).

³The First International Congress had been held at Washington D.C. in 1930. It had been followed by a second held at Paris in 1937.

⁴The decision to hold the congress in England was apparently made at a meeting convened in November 1945. See J.C. Flugel, 'Development of the Programme', *International Congress on Mental Health London 1948: Vol I, History, Development, and Organisation* (London: H.K. Lewis & Co. Ltd, 1948) 38-47, p38.

psychiatrists during the war, making two long study visits in the early 1940s.⁵ Post war he collaborated with prominent U.S. psychiatrists, including Harry Stack Sullivan, George Stevenson, Frank Fremont-Smith and the Canadian Charles Brock Chisolm, to set out an approach to the Congress that would emphasize the importance of applying knowledge on human inter-relations through the coordinated work of the psychiatric and human science professions.⁶ The Programme Committee, under the chairmanship of Professor J.C. Flugel, proposed the theme, 'Mental Health and World Citizenship', for the conference. A theme, it hoped would widen the 'mental hygiene frame of reference in a practical way'.⁷ The London Congress was thus an ambitious enterprise in its promotion of 'human relations' for positive mental health. It's practical organization was equally ambitious. Rees proposed that voluntary study groups should be set up worldwide. These were to be inter-professional groups set up to study a particular topic relevant to the general theme. 351 discussion groups reported from 21 countries. They comprised in total 4,100 people from 28 different disciplines.⁸ An International Preparatory Commission was set up in order, it was hoped, to synthesize the discussion group reports and the Congress planners themes. It was intended that the International Preparatory Commission would produce a defining document, both for the Congress and the mental hygiene movement generally.⁹ This document was published as *Mental Health and World Citizenship*.¹⁰

⁵ N.P.Manning, 'Innovation in Social Policy – the Case of the Therapeutic Community', *Journal of Social Policy* 5 3 265-79, p268-269.

⁶ *International Congress on Mental Health London 1948: Vol I*; Eugene, B. Brody, *The Search for Mental Health: A History and Memoir of WFMH 1948-1997* (Williams and Wilkins, 1998), p15 and p23-24.

⁷ J.R. Rees, *Reflections: A Personal History and an Account of the Growth of the World Federation For Mental Health* (New York: US Committee of the WFMH, 1966), p74.

⁸ *International Congress on Mental Health London 1948: Vol I*, p52-3; J.R. Rees, *Reflections*, p74.

⁹ Eugene B. Brody, *The Search for Mental Health: A History and Memoir of WFMH 1948-1997* (Williams and Wilkins, 1998), p30.

¹⁰ International Preparatory Commission Statement, printed in *International Congress on Mental Health, London 1948: Volume IV Proceedings of the International Conference on Mental Hygiene 16th –21st August*. (London: H. K. Lewis & Co. Ltd, 1948), p285-321. Published as *Mental Health and*

It sought to influence allied professions, social scientists, and administrators as well as psychiatrists and general medicine.¹¹

Many of the concepts and assumptions employed by mental hygienists before the war were perpetuated in *Mental Health and World Citizenship*. The concept of 'personality' remained a central factor in the development and maintenance of mental health. The unceasing emphasis of mental hygienists on the central importance of family life continued. And mental hygienists continued to hold together their discourse of emotionality and concomitant programmatic agenda by recourse to authoritative descriptions of historical stages of development. Re-stating popular nineteenth-century understandings of historical process, as well as biological representations of the body, *Mental Health and World Citizenship* emphasized that every individual progressed through progressive stages of 'growth, development, maturation and decline'. It was also reasserted that 'correct' development of the personality remained the underlying necessity for mental health. Healthy mental development, it was argued, must be safeguarded by matching educational and socializing processes carefully to the relevant phases of child development. And yet the centrality of human relationships to the development and maintenance of personality dominated the document. Personality development took place in a social and cultural setting made manifest through inter-personal relations. Relationships, it

World Citizenship (London: WFMH, 1948). All references are to the 'Statement' in the *International Conference on Mental Hygiene*.

¹¹ 'International Preparatory Commission Statement', *International Congress on Mental Health, London 1948: Volume IV*, p285. The document also provided the ideological basis of the World Federation for Mental Health, which was founded at the 1948 Congress and replaced the interwar International Committee for Mental Hygiene.

was now argued, were the key to understanding how personality developed from the earliest years of infancy.¹² As one of the organizers of the Congress put it:

...in some of the mental health services, particularly in those concerned with prevention, such as child guidance, involving intensive study of inter-personal relationships, a combination of the social sciences and psychiatry had led to a new approach to mental health and had helped to widen the whole concept.¹³

These inter-personal relationships were both conscious and unconscious. Internalized as part of the psychic structure they shaped expectations of others while influencing one's own behaviour and attitudes. With this approach the mental health of the child was related to the mental health of the adult in specific but subtle ways.

Psychoanalysis had, of course, since early in the century, been increasingly influential in promoting the notion that 'neurotic' symptoms amongst individuals were the common result of suppression into the unconscious of instinctual desires. The classic psychoanalytic individual was, at least partially, irrational. This person was, however, still understood and treated as a separate encapsulated individual. Medical metaphors were used to describe an atomized and individual psyche within which mental illness was held to reside. In fact, the influence of psychoanalysis was much greater at the 1948 Congress than it had been at the pre-war Congresses. And yet, the individual that emerged from the Statement, and from the 1948 Congress, was an individual whose nature was primarily formed and sustained within a nexus of human relationships. As I have mentioned in the previous chapter, much of this can be

¹² Hunter, Dugmore, 'An Approach To Psychotherapeutic Work With Children and Parents', *11th Inter-Clinic Conference For Staffs of Child Guidance Clinics: 'The Family Approach to Child Guidance-Therapeutic Techniques'*, (London: NAMH, 1955) 11-26, p12.

¹³ E.M. Goldberg, 'Group Work Before and During the Congress', *International Congress on Mental Health, London 1948: Volume I*, 51-63, p52.

attributed to what Joseph Schwartz has described as a paradigm shift in psychoanalysis from a focus on conflicts caused by unconscious drives to an understanding of a fundamental drive for relationship.¹⁴ I noted that this shift was concomitant with a similar shift in mental hygiene. But not only was an individual's mental condition to be appreciated via an understanding of the emotional effects of such relationships, so also was this individual's citizenship. Citizenship itself was conceived as an aspect of human relationships.¹⁵ To be a 'good' citizen was to be, at least partially, 'dependent' on others, not independent. To be sure the motives and desires of this citizen were largely hidden and irrational, but these emotions were to be considered much more as the product of relationships than simply as the consequence of innate instinctual drives. D.R. MacCalman, professor of Mental Health at Aberdeen University and later Medical Director at NAMH, noted at the Congress, that rather than concentrating on the individual, as clinical work encouraged, what was required was the construction of 'harmonious interpersonal relationships'.¹⁶ '[W]e are all discovering that society cannot be understood merely by studying the individuals in it: the relationships and tensions between them are also important.'¹⁷ This is not a depiction of the eponymous 'man alone', the autonomous, contractual monad of classical political science. The 'optimistic' vision of mental health and citizenship held out by these mental hygienists was not simply one of an independent rational adult but of a 'mature' (as opposed to 'immature') interdependence of human beings.

¹⁴ Schwartz, however, traces the historical circumstances informing this shift to the 'traumatic social events of war and revolution in Europe', see Joseph Schwartz, *Cassandra's Daughter: A History of Psychoanalysis* (Harmondsworth: Penguin, 1999) p12-13.

¹⁵ For a concise elaboration of this dominant theme at the Congress see, D. Mitrany, speech on, 'Problems of World Citizenship and Good Group Relations', *International Congress on Mental Health, London 1948: Volume IV*, 71-85, p83.

¹⁶ D.R. MacCalman, Speech on 'Aggression in Relation to Family Life', *International Congress on Mental Health, London 1948: Volume II, Proceedings of the International Conference on Child Psychiatry 11-14th August* (London: H. K. Lewis & Co. Ltd, 1948), 50-55, p52 and p50.

¹⁷ D.R. MacCalman, Speech on 'Aggression in Relation to Family Life', p52-3.

This description of the human relational context of personality was contrasted with 'traditional' notions of the personality as fixed at birth and therefore unalterable. Human nature, it was argued, was much more 'plastic' than had previously been realized. Critically, this 'plasticity' of development and adjustment was now directly related to the inter-personal relationships of both children and adults. What appeared to be 'progressive' and 'enlightened' about much of this language was that it held out the hope of peaceful progress towards 'human happiness' by emphasizing the malleability of human nature. Notions of human personality as 'fixed' through constitutional factors, racial characteristics, or straightforward notions of heredity were deemed both pessimistic and inaccurate. In part one can see this as a reaction to the recent world war and the need for a more hopeful vision for humanity. In part also it can be understood as an attempt to distance mental hygienists from racial hygiene measures associated with the Nazi regime. It also represents, however, the ascendance of an approach to mental health and disorder grounded in the investigation of the emotional dynamics of human relationships. But there is another aspect to this. J.R. Rees, the President of the Congress, described the aim of the congress as 'to focus interest on the sickness of groups and communities in the world'.¹⁸ At previous congresses this would certainly have encompassed the 'social problem' of mental deficiency. And coupled with the now ascendant view of a 'plastic' inter-personal personality, capable of positive change, one might have expected that there would have been some sort of explicit re-conceptualization of the nature of mental deficiency and the people so labeled. However, this did not take place at the Congress. The shift in discourse was no simple humanitarianism. Mental hygiene

¹⁸ J. R. Rees, 'Origins and Aims of the Congress', *International Congress on Mental Health, London 1948: Volume I*, 33-37, p36.

retained its ambitions to create a functionalist harmonious society within which people and institutions would fit efficiently. Knowledge and awareness of good human relations, and thus mental health, was to support these goals and continually foster the 'highest' standards of citizenship. In the post war world the threat to this vision appeared to come from lack of 'scientific' knowledge and awareness of the need for nurturing good human relationships. With such an understanding the 1948 Congress simply turned away from the 'problem' of mental deficiency. Constitutional and hereditarian histories of personality development were merely denied as scientifically useful to the creation of 'healthy' and harmonious societies. Apparently no longer a fundamental threat to the growth of civilization and an efficient society, people labeled mentally deficient were, nevertheless, not explicitly re-conceptualized in terms of the new discourse of emotional-relational health. Prescribed intellectual capacity continued to operate as a dividing line whereby separate histories of development dictated the relevance and interpretation of the discourse of emotionality.

Mental hygienists attempted to relate their aspirations to post-war democratic ideals. They re-emphasized the professed linkage between the concepts of democracy, citizenship, and mental health in a reciprocal association, held together by the assertion that a detailed understanding and application of the principles of 'inter-personal relations' could underpin these self-evidently essential objectives. None of these concepts; 'democracy', 'citizenship', 'mental health', should be taken at face value however. They are, of course, ambivalent concepts in themselves, but mental hygienists propounded the contradictory aims of idealizing such concepts as

necessarily enlightened and correct, whilst at the same time seeking to reconfigure them.¹⁹

A clear continuity of thinking with innovations at the therapeutic communities was the introduction of 'small group work' as an organizing principle for the entire Congress. In addition to the vast array of discussion groups organized world wide, the Congress itself was arranged on 'group work' lines. Each of these groups was deliberately constructed of people from various professions. It was hoped that group interaction would provide a 'community' of common purpose that would be of 'therapeutic or educational value'.²⁰ With the recent world war cast as a 'world-wide breakdown in human relations' these experiments in using the nascent 'science' of human relations through 'group work' could appear to provide the means to promote enlightened human integration. At a Congress session covering advances in group therapy W.R. Bion elucidated that therapeutic groups expressed group culture through the interaction of the 'group mentality, the attempts of the individual to achieve a full life in the group, and the culture of the group'.²¹ At the small group gatherings professionals found themselves confronted with such concepts at first hand. The generally espoused 'democratic' and egalitarian nature of this self-consciously multi-professional work was soon thrown into doubt as inter-personal difficulties became apparent. It was pointed out that problems of hierarchy remained amongst people belonging to different professional 'grades'. Opinions might not be freely aired or listened to. Moreover, apparent agreement at an 'intellectual' level in groups was

¹⁹ It should be remembered here that the contradictory nature of mental hygienist theorizing was apparent before the war – for example in regard to the nature and function of the family. See previous chapter.

²⁰ E.M. Goldberg, 'Group Work Before and During the Congress', *International Congress on Mental Health, London 1948: Volume I*, 51-63, p52.

²¹ W. R. Bion, speech on, 'Advances in Group and Individual Therapy', *International Congress on Mental Health, London 1948: Volume III* 106-110, p110.

undermined by the suspicion that emotional difficulties had not been worked through. Seemingly rational consensus might mask unconscious resistances; a common report being, 'relations amazingly friendly and civilized although antagonism known to exist outside.' Others feared that the attempt to soften group tensions and create professional accord would lead to a 'blind acceptance of conclusions reached by an emotional rather than reasoning process.' Still others were concerned that group work resulted in the mere expression of personal opinions rather than the 'discovery of facts.'²² But while the application of group interaction in practice demonstrated ambiguity and uncertainty amongst professionals, the Congress's official statement of its thinking displayed no such doubts.

Mental Health and World Citizenship asserted that the concept of the 'world citizen' was not 'of a political character'.²³ By this was meant that the term had no association with any notion of the construction of a sovereign world state,²⁴ or even of citizenship 'in any legal sense'.²⁵ And yet the whole ethos of the document was that 'human institutions' could and should be adapted in order to create 'world citizens' living harmoniously in a 'world community'.²⁶ Indeed it continued the explicit interwar proposals of leading mental hygienists that their knowledge should be employed in the selection and organization of people and agencies at all levels of society. Thus their 'insight into human beings and personality development' was to be 'recognised as

²² E.M. Goldberg, 'Group Work Before and During the Congress', *International Congress on Mental Health, London 1948: Volume I*, 51-63, p59-63.

²³ Lawrence K. Frank and Margaret Mead, 'The International Preparatory Commission', *International Congress on Mental Health, London 1948: Volume I*, 74-89, p86.

²⁴ Though the statement held out the expectation that such a body may come about. See, 'International Preparatory Commission Statement', *International Congress on Mental Health, London 1948: Volume IV*, p299.

²⁵ Lawrence K. Frank in, 'Conclusions and Recommendations', *International Congress on Mental Health, London 1948: Volume IV*, 253-27, p263.

²⁶ Though the statement held out the expectation that such a body may come about. See, 'International Preparatory Commission Statement', *International Congress on Mental Health, London 1948: Volume IV*, p299.

essential to all administration, legislation and political action.²⁷ The psychiatrist and social scientist's expertise were to be brought 'into the closest possible contact with the administrator and the political leader.'²⁸

It should be emphasized that the inherently functionalist view of society espoused through mental hygiene continued despite the focus on human relationships. Issues of gender or class, for instance, continued to be relegated by this problematic. Regarding class antagonisms for instance, the prominent mental hygienist H.V. Dicks wrote in 1948 that:

The masses of working people are, partly in reality and partly in fantasy, still carried by the momentum of this old struggle. All of us have yet to assimilate the notion of the community, of which the leadership is, as it were, the ego. That is to say, management or government is a specialized organ for integrating and carrying on the affairs and external relationships of the given group, not a remote parent-symbol ambivalently regarded as an agency menacing the individual, a prize for power drives, or as an inexhaustible milch-cow. ... The sense of meaningful community must be recreated at a higher turn of the spiral. The feeling of complexity and inexplicability which the average man has about economics, foreign politics or technological processes, leads him to turn cynically away from participation, that is, from

²⁷ Lawrence K. Frank and Margaret Mead, 'The International Preparatory Commission', *International Congress on Mental Health, London 1948: Volume I*, 74-89, p84.

²⁸ Lawrence K. Frank and Margaret Mead, 'The International Preparatory Commission', p84.

concern with the objectives of the group as if it were a bad parent, hard to understand. High social participation ... is identical with "high morale".²⁹

With the central emphasis upon knowledge of emotional relationships and health, it followed to many delegates at the Congress that the health and 'emotional development' of the individual was intimately linked with the 'health' and 'emotional development' of society. Margaret Mead, the influential anthropologist (and collaborator on the document *Mental Health and World Citizenship*), argued in a speech to the Congress, that both these aspects were integral to one another.³⁰ Indeed, the influence of anthropologists, such as Mead and her one time tutor Ruth Benedict is distinct. The respected Chicago based psychoanalyst, Franz Alexander, declared at the conference that these anthropologists had 'demonstrated the basic fact that not racial heritage but cultural influences mediated by the family are responsible for the different attitudes in people.'³¹

In all this remains the constant conjoining of the concept of 'democracy' with that of 'mental health and maturity'.³² This is despite, indeed partly because of, the incorporation of anthropological perspectives. Anthropologists such as Mead and Benedict accepted that the family was the mediator of culture and the individual. In a number of influential studies they posited the family as the central nexus through which individual and societal development were mediated. They thus accepted and

²⁹ Henry. V. Dicks, 'Principles of Mental Hygiene', in Noel G. Harris, *Modern Trends in Psychological Medicine: 1948*, (London: Butterworth & Co., 1948) 310-334, p331.

³⁰ Margaret Mead, speech on 'The Individual and Society', to the *International Congress on Mental Health, London 1948: Volume IV*, p123-4.

³¹ Franz. Alexander, speech on 'Family Problems and Psychological Disturbance', to the *International Congress on Mental Health, London 1948: Volume IV*, 148-157, p150.

³² See for example, Franz Alexander, speech on 'Family Problems and Psychological Disturbance', to the *International Congress on Mental Health, London 1948: Volume IV*, 148-157, p150.

reinforced mental hygienists' traditional emphasis on the central importance of the family to 'healthy mental adjustment'. One might expect that their cross-cultural analyses would serve to undermine prescriptive psychodynamic valuations of the family that were nation, and culture specific. And, in part, they did do this. The description of 'guilt' as a foundation for civilized behaviour promoted by mental hygienists before the war was now placed in cross-cultural context.³³ In her speech on the theme of 'collective guilt' Margaret Mead argued that character structures were associated with different social arrangements, family structures and political forms. Basing her analysis on contrasts in family socialization in various cultures, Mead argued that guilt was only one type of character structure used as a sanction in societies. As such it was only one culturally specific mediator of the relationship between family training of the young and representative government. She warned that, without a recognition of this, there was a danger that approaches to improve social arrangements in order to promote mental health developed in one society could prove ineffectual or even damaging when applied to another.³⁴ Nevertheless, while she maintained that different forms of socialization could found varying character structures in different societies, Mead's terminology suggests a hierarchical view of cultures in this respect. She noted that:

We may say, on the basis of comparative cultural data, that the capacity to experience guilt, as a dominant psychological mechanism, is a human capacity which may be either developed or neglected by any given society, and cannot

³³ For interwar mental hygiene associations of the development of 'guilt' with the development of responsible and civilized character, see, for example; Mary R. Barkas, 'Guilt', *Mental Hygiene* No.6 December, 1932, 29-33; 'Guilt and Civilization', *British Medical Journal* 2 29th October, 1932, p804.

³⁴ Mead, Margaret, speech on 'Collective Guilt', to the *International Congress on Mental Health, London 1948: Volume III, Proceedings of the International Conference on Medical Psychotherapy 11th – 14th August*. (London: H. K. Lewis & Co. Ltd, 1948) 57-66, p65.

therefore be regarded as either universal or necessary, however desirable it may be found in terms of contemporary ethics.³⁵

Guilt, as a character structure then, is considered to have been 'neglected' in societies where other character structures predominate. Moreover, its utility as a mediating factor for the organization of democracy is conceived (even if unnecessary in any *particular* culture) as desirable in terms of contemporary ethics. It would surely be legitimate to ask, 'whose contemporary ethics?' In a separate speech at the Congress Margaret Mead warned of the danger of a 'mental health imperialism' attempting to teach people of other cultures against their will. And yet she continued by saying that such peoples needed to be allowed to create their own conditions within which they could learn to use the 'new knowledge which modern science has made available to mankind'. The application of this knowledge she asserted was a necessity if mankind was to survive and to 'develop more of human potentialities'.³⁶ This 'scientific' knowledge was however an aspect of thoroughly western medical and social science. The implication here is surely that the sciences of human relations should underpin *all* cultural improvements and indeed, determine which cultural changes were in fact improvements. Other speakers at the Congress were more forthright. The senior Tavistock Clinic psychiatrist H.V. Dicks was a major figure in the developing study of 'national character'. He commented that 'some of the societies which Dr Mead [had] quoted as having little guilt and much shame or pride or just sheer external

³⁵ Mead, Margaret, speech on 'Collective Guilt', to the *International Congress on Mental Health, London 1948: Volume III*, 57-66, p64.

³⁶ Mead, Margaret, speech on 'The Individual and Society', to the *International Congress on Mental Health, London 1948: Volume IV*, 121-127, p126-7.

compulsion for the coercion of their members, seem to stand on a psychologically less mature rung of the ladder.³⁷

In Britain the concepts of 'democracy', 'mental health' and 'maturity' were employed by mental hygienists as key criteria in their vision of a national network of prophylactic mental health measures. A flavour of the way in which such notions were utilized can be gleaned from a 1949 paper by D.W. Winnicott for the journal *Human Relations*.³⁸ His paper was entitled 'Some Thoughts on the Meaning of the Word Democracy'. On the surface Winnicott appears to be arguing in this paper that an 'enlightened' psychological approach to the family, and to child rearing in particular, would be the best way to preserve democracy. Indeed, Winnicott seems to maintain that this 'enlightened' approach to the healthy development of children relies on *less* interference by professionals with the early mother- infant relationship. 'The most valuable support', he wrote, 'is given in a negative way by organised non-interference with the ordinary good mother-infant relationship, and with the ordinary good home.'³⁹ What could be more democratic than non-interference with the sacrosanct 'private' home of the 'ordinary' 'good' citizen? The key to Winnicott's argument lies elsewhere, however. In one convoluted sentence he managed to compress several unclear terms with a number of dubious assumptions and thus come up with an apparently clear-cut assertion. 'If democracy is maturity, and maturity is health, and health is desirable, then we wish to see whether anything can be done to foster it'.⁴⁰ The 'we' here was, of course, Winnicott himself and his fellow

³⁷ Dicks, H.V., Contribution to debate on 'Collective Guilt', *International Congress on Mental Health, London 1948: Volume III*, p84.

³⁸ Winnicott, D. W., 'Some Thoughts on the Meaning of the Word Democracy', *Human Relations* 3 2 175-186.

³⁹ Winnicott, D. W., 'Some Thoughts on the Meaning of the Word Democracy', p181.

⁴⁰ Winnicott, D. W., 'Some Thoughts on the Meaning of the Word Democracy', p179.

professionals working in psychology and psychiatry. Winnicott's easy equation of 'democracy' with 'maturity' and of these terms with 'health', echoed the voices of the various professionals and their pronouncements at the International Congress on Mental Health a year earlier. Indeed, Winnicott defined 'democracy' as 'society well adjusted to its *healthy* individual members.' A definition in accord, he noted, with that expressed by R.E. Money-Kyrle at the Congress.⁴¹ How then did Winnicott suggest that 'we' (medical professionals) foster this secular Holy Trinity of democracy, maturity, and health? First he attempted to define his terms of 'health' and 'maturity'. In this endeavour he apparently regarded algebraic notation as useful for the necessary understanding of the 'types' of individuals inherent within any (presumably western) society. Thus, he listed, 'anti-social individuals' – X%; Individuals who 'immaturely identify with authority' – Z%; Individuals whose maturity is 'indeterminate' – Y%. Therefore the percentage of people in society who were 'healthy individuals capable of social contribution' = $100 - (X+Y+Z) \%$. All is now clear! One can't help wondering whether all this algebraic nonsense reflected a concern in Winnicott with a perceived necessity to be objective. This was apparently medical science after all. Specious objectivity or not, Winnicott's psychological pronouncements on democracy were shot through with arbitrary claims and moral judgements. He maintained, for example, that a psychological study of the concept of 'democracy' was justified where implied in the term was the concept of maturity. (Apparently the nebulous term 'maturity' automatically sanctioned psychological investigation – and moral pronouncements). And since Winnicott had already asserted (quite arbitrarily) that a democratic society was by definition 'mature' there was clearly need for psychologists to tell the rest of the population how and why this

⁴¹ Winnicott, D. W., 'Some Thoughts on the Meaning of the Word Democracy', p176. Italics in the original.

was so and how to continually foster such 'maturity'. But, in fact democratic society, according to Winnicott, was not simply 'mature'. It was contaminated and weakened, as we have seen, by unknown numbers of 'X', 'Y' and 'Z's. Thus democratic society was only mature in that it had 'a quality that is allied to the quality of individual maturity which characterizes its healthy members'.⁴² What sort of people did Winnicott consider the 'weakeners' of democracy? Winnicott answered this with regard to parents: They are 'psychiatric cases, or they are immature, or they are anti-social in a wide sense, and socialized only in a restricted sense; or they are unmarried, or in unstable relationship, or bickering, or separated from each other, and so on.'⁴³ One wonders whom this might leave out. This is no description of democracy; it is a vision of medical oligarchy. And it mirrors the pronouncements of more prominent mental hygienists, such as J.R. Rees. Mental hygienists, of course, did not stop at claiming the right to decide what 'healthy citizenship' was but also envisaged the right to select the country's rulers. 'It is a legitimate fantasy', wrote Rees in his 1945 book *The Shaping of Psychiatry by War*, 'that a truly democratic country may in the future choose its legislators on grounds of personality and character instead of selecting them for those reasons that now obtain.'⁴⁴ Quite how the selection of legislators by a self-appointed group of mental hygienists represents 'true democracy' remains unclear.

I have chosen to dwell on, what is a relatively obscure paper by Winnicott because it encapsulates the fundamentally contradictory nature of this theorizing. Mental health (maturity) and social efficiency were deliberately and explicitly expressed in terms of 'social democratic' principles. This, however, was a social democracy that was to be

⁴² Winnicott, D. W., 'Some Thoughts on the Meaning of the Word Democracy', p175.

⁴³ Winnicott, D. W., 'Some Thoughts on the Meaning of the Word Democracy', p179.

⁴⁴ Rees, J.R., *The Shaping of Psychiatry by War* (Chapman and Hall Ltd, 1945) p150.

underpinned and guided by an expert therapeutic authority that scrutinized the relations and interactions between people. Indeed, Winnicott's characteristic easy going and 'reasonable' style only serves, to reinforce the 'obviousness' and therefore authority of such assertions. There is little here that could be said to parallel NAMH's later adoption of a strategy intended to defend the civil and social rights of mentally disordered people themselves. Its director pungently remarked, in 1985 for instance, that the mental health services, 'erode self-determination, demolish citizenship and withdraw power.'⁴⁵ Nothing in Winnicott's paper, or at the International Congress, appears to echo this.

Nevertheless Winnicott's paper needs also to be understood, I think, as representative of an ascendant view that posited emotions and relationships as central to an understanding and treatment of children and adult's mental health. However obscured by professional paternalism and empire building, this reconfigured understanding of the nature, and constitution, of mental health and disorder, had ramifications for the roles, and expectations, of mental health workers and patients alike. As mental hygienists continued their traditional emphasis on surveillance and treatment of the community they increasingly deployed this reconfigured understanding of mental health and disorder in this wider realm. The conjoining of 'health', 'maturity', and 'citizenship' under the rubric of 'human relations' entailed an emphasis on the individual as essentially emotionally endowed; the cipher of human relationships. In the process the contours of mental health and disorder became blurred. Meanwhile the power relation that the neo-moral therapy of mental hygiene represented became itself conceived as part of the problematic field. We have already seen that much of

⁴⁵ Chris Heginbotham, xerox copy of speech on, 'Consumer Choice: Change and Conflict in Community Care', given at Oldham A.M.A. Conference, 27th September, 1985, p1. (MIND archive).

this had been suggested in mental hygienists' own wartime experimental schemes. I show the further influence of these factors in the next chapter. But here I show that it was, ironically, initially in the realm of mental deficiency that these power relations were publicly exposed as at their most blunt and explicit. It was here that the mental hygiene problematic and civil libertarianism first clearly conjoined.

Mental Deficiency: '50,000 Outside the Law'.

'But this stubbornness of which I speak is *unreasoning* stubbornness; complete unwillingness to listen to, let alone acknowledge, the other man's point of view... '

(Ian Skottowe on 'character defects' in certain people diagnosed as 'high-grade' mentally defective).⁴⁶

From the late 1940's, and throughout the 1950's, the National Council for Civil Liberties (NCCL) conducted a civil libertarian campaign against the operation of the mental deficiency system. Authors who have commented on this campaign have largely described it in terms of the straightforward application of a civil libertarian discourse against the operation of the mental deficiency system.⁴⁷ In this section I want to show that this was not the case. I will reconsider the NCCL campaign in

⁴⁶ Ian Skottowe, 'Some Aspects of Character Defect', *Mental Welfare* 16 No.4, October 1935, 77-81, p79. (Italics in the original). 'There then, are the clinical criteria of a clearly defined form of character defect: inability to apply oneself: unreasoning stubbornness towards authority and a capacity for being "easily led" by the wrong kind of people.' (p80).

⁴⁷ See, for example, Tim Stainton, 'Equal Citizens? The Discourse of Liberty and Rights in the History of Learning Disability', in, Lindsay Brigham, Dorothy Atkinson, Mark Jackson, Sheena Rolph and Jan Walmsley, *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster: BILD, 2000); Mathew Thomson; *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c.1870-1959* (Oxford: Clarendon Press, 1998); Clive Unsworth, *The Politics of Mental Health Legislation*, (London: Clarendon Press, 1987); Greta Jones, *Social Hygiene in Twentieth Century Britain* (London: Croom Helm, 1986).

terms of the changing nature of the mental hygiene problematic that I have been tracking. Certainly the campaign publicly raised the ire of NAMH and individual mental hygienists, but beneath this public dispute the situation was more complex. Mental hygienist's continued conception of mental deficiency as an aspect of historically retarded human development militated against the forthright application of the newly reconfigured problematic of emotional relationships to mentally deficient people. But, in fact, I will show that civil libertarianism found common ground with psychological and psychiatric approaches founded on this shifted problematic. Indeed the NCCL deliberately used such new psychological thinking to buttress its call for change. And, as with the changes in approach to childcare and at therapeutic communities, this encouraged further sensitivity to the impact of emotional relationships and challenged autocratic authority. In this section I first recap on the development of the mental deficiency system in terms of the conceptualization of mental hygiene. I then discuss a main aspect of the campaign, which was against the extended use of the concept of 'social inefficiency'. I show that this was a key area of dispute between the NCCL and many mental hygienists.

The mental deficiency system remained an area where medicine and overt social control appeared at their most intimate and obvious. The main targets of the 1913 Mental Deficiency Act had been 'high-grade' people labeled feeble-minded who had not previously been subject to special legislation. Many legal safeguards operative under the then existing Lunacy Act were not transferred to the Mental Deficiency legislation.⁴⁸ The Board of Control held sole right of discharge and escape could no longer act (as under the Lunacy legislation) as a means of formal discharge. At the

⁴⁸ Clive Unsworth, *The Politics of Mental Health Legislation*, p153-4.

same time the Radnor Commission, which had preceded the Act, had estimated that, other than those already in institutions, around 66,000 feeble-minded people required provision beyond mere supervision. Throughout the 1940's and 50's the mental deficiency system remained coercive in nature and its institutions custodial. The system of ascertainment, segregation and treatment of people labeled feeble-minded was built upon a concept of individual character as an historical development inseparable from the historical development of civilized society itself. Society had a moral 'character' which was an historical achievement indissoluble from the historical development of individual character. The latter, however, was historical in both biographical and human evolutionary terms. It had been on the basis of such a conceptualization that the 'expert' administrators, social reformers and doctors who agitated for a Mental Deficiency Act had asserted that their knowledge of these histories of development necessitated urgent state and voluntary action for the welfare of the community and the individuals within it. I have shown that the discourse of emotionality developed by mental hygienists between the wars had minimal effect in this sphere. This was largely because this newer conceptualization of historical stages of emotional growth was superimposed upon the former delineation of the evolutionary development of individuals and society. Posited intellectual capacity performed the means of demarcation between these two histories. In consequence emotional experience and expression of feelings was construed and acted upon quite differently either side of this divide. Mental hygienist's acknowledgement of the centrality of emotional sensitivity in those deemed to be above the intellectual divide was, in any case, an acknowledgement to an end. Responsible and efficient citizenship was to be constructed through rational awareness and shaping of the emotions. But both 'lower' and 'higher grades' of mentally deficient people were

retained beneath this divide. Their emotionality was largely construed as an aspect of 'lower' levels of functioning. Most were deemed to lack the capacity for full and responsible citizenship. Those that had the potential were considered to require firm authority and the control of an emotional instability that was largely conceived as an innate aspect of their arrested development. Though 'progressive' mental hygienists promoted a vision of mental deficiency institutions as the specialist hub of a more fluid network of agencies of 'socialization' they continued to view mental deficiency as requiring surveillance and control. Where the discourse of emotionality did have an effect it was in terms of the need to 'stabilize' emotionality. Whilst intellectual incapacities could not be fundamentally altered, it was argued that order and discipline could rein in erratic emotionality and allow some to take their place in the community.

But despite these 'progressive' ideas, the mental deficiency system remained an ever-growing backwater, where pessimistic attitudes to individual development and change endured. Moreover, rather than encouraging a fundamental re-conceptualization of the care and treatment of people labeled mentally deficient, the newly ascendant understanding of health and good citizenship in terms of the dynamics of emotional relationships tended instead to encourage a focus away from mental deficiency. By fiat mentally deficient people had been defined and categorized as a threat to the progress of humanity. Now, by fiat, they were apparently much less so. But, whilst people labeled mentally deficient were now not the primary cause of social 'retardation', they were also ruled out of being significant participants in the 'healthy' development of civilization under the rubric of a science of human relations.

But from the later 1940's other voices came to be more powerfully heard. The National Council for Civil Liberties began to campaign against the mental deficiency system. An elderly hospital chaplain and a retired accountant had garnered their support. Both of these men had separately discovered cases of children they believed to have been unjustly detained in mental deficiency institutions. They reported the cases to the NCCL who, on investigation, began a national campaign.⁴⁹ The NCCL attack brought to bear a civil libertarian discourse necessarily focused primarily on the present. This could appear in stark contrast to the underlying import of history, as developmental or retarded, which was deployed as part of the mental hygiene problematic. But, in fact the civil libertarian approach dovetailed with significant aspects of the reconfigured problematic which placed central concern on the nature of emotional relationships. It was in these relationships that mental health or ill health became manifest. As I have emphasized, this directed attention to relational activities and organizational procedures in the present, in terms of their capacity to create health or illness. Sensitivity to relationships implied less overt control and discipline. Coupled to this conceptualization was an emphasis on liberty, personal possessions, contact with the outside community, and a rejection of autocratic authority: all of these were justified as requisites for the creation of emotional relationships that would nurture social adjustment, responsibility, and therefore mental health. The mental hygiene problematic, conceived in these terms, could clearly complement aspects of civil libertarianism.

In the post-war years, with the new Labour government's sweeping social legislation, health and welfare was increasingly expressed in terms of rights. The NCCL was able

⁴⁹ *Royal Commission on The Law Relating to Mental Illness and Mental Deficiency 1954-57, Minutes of Evidence*, p793; *Reynolds News*, 25th October, 1953.

to employ this terminology in order to challenge psychiatric policies. The NCCL campaign has been depicted, as a straightforward attempt to expose the number of people being compulsorily detained who were not in fact mentally deficient.⁵⁰ And, indeed, this was a strong element of the campaign. Much of the criticism concentrated primarily on the detention of people labelled feeble-minded. It was argued that many people so detained were in fact 'normal' and should never have been certified. The main support for this campaign came from socialist organisations. Independent Trades Unions, and Trades Councils supported the campaign and helped to organize conferences up and down the country. So too did the Socialist Medical Association and Medical Practitioners Union.⁵¹ Ex-patients, and relatives or friends of patients in institutions, were encouraged to attend and make their views heard.⁵² While the newly founded NAMH stated the need to educate the public on what was being done in the field of mental health, the NCCL similarly announced that it was time that the 'ordinary man and woman' became informed on the subject of the treatment, training and employment of people who were mentally retarded.⁵³ The NCCL's publicity campaign was, however, less paternalistic and reassuring. It raised concern that some parents, unaware of the details of the Mental Deficiency Act, had been persuaded to sign consent forms for their 'backward' child leaving a special school, or their adolescent experiencing emotional problems. These parents, it was claimed, had done so under the belief that their children would receive a year or so's

⁵⁰ For instance, Nancy Korman and Howard Glennerster, *Hospital Closure: A Political and Economic Study* (Milton Keynes: Open University Press, 1990), p12.

⁵¹ NCCL archives, DCL 631.4; DCL 631.6.

⁵² DCL 631.6 NCCL publicity letter for a conference on Mental Deficiency Laws and Administration, Broad Street Birmingham November 1956.

⁵³ NAMH, Annual Report, 1948-49, p6; DCL/631.6 Promotion for Conference on Mental Deficiency Laws and Administration, to be held at Transport House, Broad Street, Birmingham, 24th November 1956.

training but had found out afterwards that they had no further say over what turned out to be an indeterminate period of detention.⁵⁴

Socialist organizations were not only concerned about particular instances of clearly wrongful committal but also of the extension of compulsory detention powers based on medical determination of 'social defectiveness', often using the category 'moral defective' under the existing Act. The Socialist Medical Service itself investigated a number of cases. It declared itself determined to fight class distinctions with regard to mental deficiency certification, and denounced certification based on 'social circumstance' rather than intelligence quotient.⁵⁵ One of its members, Dr Brian Kirman, the deputy Medical Superintendent of the Fountain Mental Deficiency Institution at Tooting, spoke at a Conference arranged with the NCCL in 1950.⁵⁶ He warned his audience that some psychiatrists (especially, he believed in the United States) wanted to lock up anybody who had crossed the authorities. Kirman maintained that, very often, the criteria for locking people up as mentally deficient was that they were considered as 'obviously that type belonging to a low class, the scum of society – somebody you didn't like the look of.'⁵⁷ A resolution subsequently passed by the conference condemned what it saw as the tendency to extend mental deficiency to encompass those exhibiting a lack of 'social adaptation' rather than intelligence.⁵⁸ In early 1952, Brian Kirman reiterated these views in the more sober language required for the *Nursing Times*:

⁵⁴ DCL/631.6 Promotion for Conference on Mental Deficiency Laws, Birmingham, 24th November 1956.

⁵⁵ *Daily Worker*, 2nd March 1950.

⁵⁶ *Daily Telegraph*, 5th June, 1950.

⁵⁷ *Reynolds News*, 16th April, 1950.

⁵⁸ *Reynolds News*, 16th April, 1950.

Most ordinary people who have thought at all about mental defectives, including magistrates called upon to sign detention orders, expect the patient to be obviously stupid or childish. It is surprising therefore to find, as sometimes happens, people labeled as mentally 'defective' who have passed difficult examinations, speak two languages fluently or who, on tests, have proved to possess an intelligence well above average. Although most people do not regard such people as mentally defective, quite an influential body of psychiatrists and other health workers are prepared to support the inclusion of this group of cases as 'socially defective'.⁵⁹

Such examples of patient's abilities do not appear to have been particularly rare. In 1958 a social worker working at one mental deficiency institution commented (uncritically) on the number of discharged patients who returned to pay visits at the weekend in their own cars.⁶⁰ In a similar vein, a Medical Officer of Health, who in 1945 reported investigations into employment in the community of people previously diagnosed mentally deficient was surprised to find that one was earning more than the welfare worker supervising him.⁶¹ Kirman continued his article by claiming that psychiatrists, and magistrates might be too ready to judge cases according to their own moral standards with little understanding or sympathy for the class and surroundings of those they were dealing with.⁶² The NCCL made similar criticisms about apparent class and moral prejudices.⁶³

⁵⁹ Brian H. Kirman, 'The Law and Mental Deficiency', *Nursing Times* 19th January, 1952, p63.

⁶⁰ Margaret E. Cripps, 'Proposals Concerning Mental Deficiency', *British Journal of Mental Deficiency* 4 No.4, (1958) 24-26, p25.

⁶¹ J. S. Cookson, 'Supervision of Mental Defectives in the Community', *British Medical Journal* 20 January 1945, p91.

⁶² Brian H. Kirman, 'The Law and Mental Deficiency', p63.

⁶³ NCCL, *50,000 Outside the Law* (London: NCCL, 1951), p27.

In fact, Brian Kirman's boss, L.T. Hilliard, the Medical Director of the Fountain institution was also involved in the campaign.⁶⁴ In an article for the *British Medical Journal* he wrote that:

A scrutiny of the medical certificates which originally formed the basis for the detention of these patients makes one wonder if enough care was given in some cases to the evidence on which diagnosis of mental defect was based.⁶⁵

These views were certainly at odds with the views of many prominent mental hygienists. Kenneth Soddy, the first Medical Director of NAMH wrote, in an article on the role of mental hygiene, that:

...the lowest socio-economic groups of the community [show] the highest incidence of insanity, neurosis, children's maladjustment, mental deficiency, crime and delinquency. These groups contain the bulk of the people of dull and backward intelligence, whose difficulties in life are all the greater because inferior intelligence tends to be linked with inferior emotional stability; they also present a further menace to the community because of a disproportionately high fertility rate. These sections of the population, therefore, are of particular significance to mental hygiene.⁶⁶

⁶⁴ DCL/24.2, Letter from Medical Practitioners Union Gen Sec Dr. Bruce Cardew to Gen Sec NCCL Elizabeth Allen 6th Dec 1954.

⁶⁵ L.T. Hilliard, 'Resettling Mental Defectives: Psychological and Social Aspects', *British Medical Journal*, 12th June, 1954, 1372-1374, p1374.

⁶⁶ Kenneth Soddy, 'Mental Health', *International Health Bulletin of the League of Red Cross Societies*, 7 No.2, April-June, 1950, 8-13, p11.

Other mental hygienists expressed associated views. The psychiatrist David Stafford-Clark, a member of one of NAMH's standing committees throughout the 1950's, produced a book entitled *Psychiatry Today* for the popular Pelican series. In a section covering mental deficiency he wrote that idiots were:

...in fact considerably less intelligent than domestic animals. Their habits are simple and unformed and their emotional responses crude in the extreme. ... unlike imbeciles ...they may be neither happy nor unhappy in the accepted sense of these descriptions.⁶⁷

Of 'imbeciles', he wrote: 'Allowed to roam about without care or supervision they may commit murder, rape, or arson' And of mental deficiency in general he contended: 'A high proportion of the ranks of prostitutes, vagrants, and petty recidivists are found on examination to suffer from a degree of mental defect.'⁶⁸ A review in the NAMH periodical *Mental Health* praised the book highly as done 'superlatively well' and 'never prejudiced'.⁶⁹

Such, apparently authoritative views permeated more general texts on health and hygiene.⁷⁰ Less emphasis on intelligence test scores and more on 'deficiencies' in character and temperament was coupled with the notion of such people having 'inferior emotional stability' in an apparent continuation of extension of the remit of

⁶⁷ David Stafford-Clark, *Psychiatry Today* (Harmondsworth: Pelican, 1952), p89.

⁶⁸ David Stafford-Clark, *Psychiatry Today*, p89.

⁶⁹ *Mental Health* 8 No.1, Autumn 1953, p37.

⁷⁰ For just one instance see, M.B. Davies, *Hygiene and Health Education For Training Colleges* (London: Longmans Green & Co., 1944) (Third Edition) One of many examples in this book reads: 'Defectives, too, are often sexually uncontrolled, lacking as they do the imagination to evaluate the social stigma that results from lack of control. The women tend to propagate their wastrel class by having illegitimate children; the men are of the class that commits emotionally disturbing and terrifying sex assaults of varying kinds.' (p244).

mental deficiency diagnosis. Curran and Guttman, in the 1945 edition of their *Psychological Medicine: A Short Introduction to Psychiatry*, claimed in regard to mental deficiency, that feeble-minded people, since the majority of them were at large in the community, constituted the problem of greatest medical and social importance. The text continued to blithely ally feeble-minded people with crime, prostitution, and sexual disease. The authors simultaneously maintained that diagnosis of feeble-mindedness was a relatively simple matter, but that doctors were failing to recognize the large number in their midst:

A considerable proportion of those who seem maddeningly incapable of giving a straight answer or a consistent history are morons [feeble-minded], and all doctors see a large number because hypochondriacal reactions are very frequent amongst them. ... It is, however, worth remembering that minor degrees of mental deficiency are fairly common in the lower strata of the community, and that such persons are often useful members of the population not easily replaced in the performance of dull and simple tasks.⁷¹

Other than the obvious class bias, what is clearly apparent in such texts is the continuing view that feeble-minded people's emotional experience and expression lay on an inferior level to those of more 'normal' people. They were depicted as 'excitable', 'restless', with 'poor powers of self-restraint or "inhibition" '. They were often 'hypochondriacal', with moods that were 'inconsistent', 'shallow', and 'impulsive'. But this array of categorized emotions was a description only of the apparently innate

⁷¹ Desmond Curran and Eric Guttman, *Psychological Medicine: A Short Introductory to Psychiatry* (Edinburgh: E & S Livingstone, 1945), p91-2. 'All that is usually required is to take a brief history and to carry out suitable tests which do not usually take much time' (p91) '...a question or two about the school record', a few about the work record, and 'a short conversation about the front page of the news should enable the doctor to form a fair estimate of the patient's intelligence'. (p224).

characteristics of such people. These were not to be understood as emotions significantly constituted in reciprocal relation with other people. Indeed there was no suggestion that they might be perfectly understandable responses to particular situations. On the contrary, these were still considered 'brute' feelings requiring unsophisticated diagnosis and management. Environmental factors were considered only in terms of the need for greater awareness of the number of feeble-minded people in the community, and the requirement for their control and disciplining.

The NCCL disputed this one-way medical depiction of feeble-minded people. It challenged the authority of such diagnoses and questioned the nature of the 'treatment' and 'rehabilitation' predicated upon them. In so doing it incurred the anger of many psychiatrists and mental hygienists. In public at least, this appears to have been the reaction of NAMH. Its public response to the NCCL's criticisms was hostile. In an exchange of letters between the Secretary of the NCCL and Kenneth Robinson M.P., a member of one of NAMH's standing committees (and later Minister for Health) the latter remarked that the mental deficiency institutions had long been a 'favourite windmill' of the NCCL and that the 'wild tilting' of its Secretary ran true to form. He continued by accusing the organization of 'deep prejudice' and 'ignorance' of the mental health system.⁷² In response to the NCCL's allegations NAMH sent out written enquiries to institutions. It sought information on the extent to which mentally defective people on license were recalled against the wishes of their parents, or guardians, and the number of occasions children labelled educationally subnormal were transferred directly to a mental deficiency institution on leaving residential special schools. The NAMH pronounced itself reassured by the responses. A special

⁷² *The New Statesman and Nation*, 2nd April, 1955; 16th April 1955; 23rd April 1955. (Quotes from 23rd April 1955). Kenneth Robinson was made a Vice-President of NAMH in 1958.

meeting of the Mental Deficiency Sub-Committee, held to consider the NCCL's allegations published in *50,000 Outside the Law*, decided that, whilst reform of the administration and legislation on mental deficiency was needed, the NCCL's report had been, 'limited and prejudiced' and that it had 'distorted' the true picture.⁷³

And yet there is another level to the engagement between the NCCL and mental hygiene. Both Brian Kirman and his Medical Director L.T. Hilliard were, in fact, involved with work for NAMH. Hilliard was a member of a mental deficiency sub-committee at NAMH early on in its formation after the war. In 1953 he became a member of the Association's Honorary Medical Panel.⁷⁴ Brian Kirman also had contacts with NAMH. He spoke at NAMH conferences and co-wrote a book on Mentally deficient children for the organization.⁷⁵ Indeed, the Fountain hospital was itself closely linked with NAMH. In the early 1950's it provided the location for a NAMH advisory service, which carried out experiments in training mentally defective children and women.⁷⁶ Hilliard and Kirman, in fact, developed the Fountain as a center for multi-disciplinary research and training.⁷⁷

The NCCL also made use of other psychiatric and psychological expertise. One of those who provided substantial advice was the psychologist Jack Tizard.⁷⁸ At this

⁷³ NAMH *Annual Report*, 1950-51, p10-11. See also the review of the NCCL's booklet *50,000 Outside the Law*, in *Mental Health*, 10 No.3 Spring, 1951, p80; NAMH, Fifth Annual General Meeting 9th January 1952.

⁷⁴ NAMH *Annual Reports*, 1947-48 through to 1953-54.

⁷⁵ NAMH, *Annual Report*, 1950-51, p10; NAMH, *Mentally Handicapped Children: A Handbook for Parents* (London: NAMH, c1954). The NAMH also printed as a pamphlet, 'The Backward Child', reprinted from an article by Brian Kirman published in the *Lancet*.

⁷⁶ NAMH *Annual Report* 1949-1950, p14, and 1950-1951, p13.

⁷⁷ Foreword by Jack Tizard to, Brian Kirman and Joan Bicknell, *Mental Handicap* (Churchill Livingstone: London, 1975), pv; Stanley Segal, *Society and Mental Handicap: Are We Ineducable?* (Tunbridge Wells: Costello, 1984), p56.

⁷⁸ A.D.B. Clarke and B. Tizard, *Child Development and Social Policy: The Life and Work of Jack Tizard* (Leicester: The British Psychological Society, 1983), p3. Tizard was a passionate egalitarian

time he was working on occupational aspects of mental handicap. He had been recruited and directed towards work on mental deficiency by the psychiatrist Aubrey Lewis at the recently established Medical Research Council Social Psychiatry Unit. Tizard, and his colleague Neil O'Connor, were to carry out increasingly influential studies in mental deficiency throughout the 1950's and 60's. Some of this research was based at the Fountain hospital. Moreover Aubrey Lewis was a longstanding member of NAMH, serving on standing committees throughout the 1950's and 60's. He was made a Vice-President in 1966.⁷⁹ In their professional writing Tizard and O'Connor did not overtly support the NCCL campaign. But their research should be seen as complementary to the NCCL's analysis of the mental deficiency system. I shall now show how this joint work furthered the analysis of mental disorder in terms of emotional relationships, and contributed to undermining the authority upon which mental hygienists based much of their ability to, define and mediate the health of the individual, and of society.

The criticisms of the NCCL, along with the psychologists and psychiatrists I have mentioned who supported it, placed diagnosis, institution and treatment in question. It was maintained that the mental deficiency system actually hindered 'social adjustment' and 'stabilization'. Indeed many people, it was argued, could and should have been helped or treated by other methods. The effect of labelling these people feeble-minded and treating them under the mental deficiency laws was shown, not only to produce stigma, but actually to promote social disempowerment and 'social problems'.

and a member of the Communist party at this time, as well as the Ex-Serviceman's Movement for Peace (the forerunner of CND).

⁷⁹ See NAMH *Annual Reports*, 1944-6 through to 1966-7.

The NCCL reversed the previous logic of mental hygiene upon which mental deficiency legislation had been predicated. It pointed out that three-quarters of those detained were diagnosed feeble-minded. With around 55,000 subject to detention orders in England and Wales, and 50,000 under statutory supervision or guardianship, the NCCL emphasized that the remainder of the estimated 350,000 mentally deficient people in the community managed to 'get through life without securing the attention of the authorities.'⁸⁰ With this view they were implicitly challenging the mental hygienist view that the social development of the community was threatened by the arrested development of mentally deficient people. In effect they were contesting the elision of community and individual progressive 'interests', based on recourse to the delineation of historical progress, mediated by mental hygienists. But, at the same time, the NCCL was able to make use of research by Jack Tizard and Neil O'Connor that showed that the IQ of patients classified as feeble-minded had been underestimated by earlier and less sophisticated tests. These studies judged the average IQ of people detained as feeble-minded at over 70%; and thus that the bulk of these people were not actually mentally 'arrested' but educationally 'backward'.⁸¹ With such authority the NCCL were able to argue that if these people did require help it should be more in keeping with their difficulties. And, along with Tizard and O'Connor, they were also able to challenge the traditional association of mental deficiency with crime, pointing out that the vast majority had no record of this or delinquency.⁸² In a speech on 'Adult Defectives and their Employment' at a NAMH conference in 1953,

⁸⁰ NCCL, *50,000 Outside the Law*, p8.

⁸¹ Jack Tizard, 'The Abilities of Adolescent and Adult High Grade Mental Defectives', *Journal of Mental Science* 96 No.405 October 1950, 889-907; Jack Tizard and Neil O'Connor, 'The Occupational Adaptation of High-Grade Mental Defectives', *Lancet* 2 1952, 6-20; NCCL, *50,000 Outside the Law*, p22.

⁸² *Telegraph and Argus* 29th March, 1951, Letter from Elizabeth Allen, General Secretary of NCCL on 'Mental Deficiency Laws'; Jack Tizard and Neil O'Connor, *The Social Problem of Mental Deficiency* (London: Pergamon Press, 1956).

Tizard strongly questioned the traditional medical view of mental deficiency as relatively easily categorised and diagnosed.⁸³ He pointed out that the results of prevalence surveys of children and adults in the community showed that '...many individuals who, as children, were or would have been found to be mentally deficient, in later life became useful and well adjusted citizens who do not require special attention or supervision.'⁸⁴ In common with the NCCL, he emphasized that the criteria for ascertaining mental defect was largely 'social and occupational competence'.⁸⁵ In terms of the latter, Tizard maintained that with guidance and training, a considerable number of 'high grade' defectives could hold down normal jobs in the community.⁸⁶ In terms of the former, Tizard cited evidence from a survey of 12,000 patients in mental deficiency institutions, which he and his colleagues had carried out. It showed, he argued, that the 'great majority of patients appeared to be inoffensive, docile people who constituted no danger to society...'.⁸⁷ Very few of those surveyed could be considered violent or dangerous, he noted, and 'contrary to general opinion' less than four percent of female patients had ever had VD or been pregnant. Only just over five percent of male patients had any history of indecent assault or exposure.⁸⁸ This conclusion about the likelihood of pregnancy, or of contracting (and presumably passing on) VD was not endorsed by some psychiatrists. One, responding to a published letter by the Secretary of the NCCL citing this research, suggested that the reason that the incidence was so low was because institutionalization had prevented feeble-minded 'girls' having the 'opportunity'.⁸⁹ Thus

⁸³ Jack Tizard, speech on 'Adult Defectives and their Employment', NAMH, *The Practical Application of Research and Experiment to the Mental Health Field: Proceedings of a Conference held at Royal Victoria Halls, London, W.C.1 5th-6th February 1953* (London: NAMH, 1953) 46-56.

⁸⁴ Jack Tizard, 'Adult Defectives and their Employment', p48

⁸⁵ Jack Tizard, 'Adult Defectives and their Employment', p48

⁸⁶ Jack Tizard, 'Adult Defectives and their Employment', p48

⁸⁷ Jack Tizard, 'Adult Defectives and their Employment', p50

⁸⁸ Jack Tizard, 'Adult Defectives and their Employment', p50

⁸⁹ *New Statesman and Nation* 12th June, 1954.

this psychiatrist was, in effect, arguing for preventive detention. Presumably he did not believe that this recourse should apply to the rest of the female population. Indeed, the fact that some detentions did indeed amount to preventive detention in general appears to have gone largely unacknowledged by psychiatric staff. For example, a study of admissions to one hospital in the mid- 1950's recorded without comment, that 10 of its sample of 100 had been certified because social workers had failed to find employment for them and they 'feared mischief if unemployment continued'.⁹⁰

Nevertheless, on the basis of work such as Tizard's, the NCCL was able to question the 'rehabilitative' function of, both the institution, and the system of licencing. The emotional effects of the present system on patients were shown in order to highlight the detrimental effects of licencing and treatment. The NCCL criticized prolonged indefinite licencing and the strict prohibition on forming attachments with anybody of the opposite sex. It pointed out that, not only were these restrictions 'incredibly cruel' and humiliating, but that they placed an unfair burden on people already burdened with having to prove their worth and 'efficiency' in the community.⁹¹ As the NCCL pointed out:

Parliament has never knowingly approved the principle that association with the opposite sex must wait upon the attainment of a certain mental level, and

⁹⁰ Michael Craft, 'The Place of the Mental Deficiency Hospital in a Community Care Programme', *Mental Health* 18 No.2 Summer 1959 60-64, p61.

⁹¹ NCCL, *50,000 Outside the Law*, p7 and 26. The NCCL cited the case of 'Victoria' who's licence was cancelled and consequently who spent another four years in a mental deficiency institution because she had been to the cinema with a young man who attended the same church.

the 200,000 or so mental defectives who have never been found to be in need of care and protection naturally suffer no such disability.⁹²

It continued by pointing out that there was nothing in the Mental Deficiency Acts themselves to justify the clause. It had, in fact, been slipped into a statutory form included in the appendix to the Mental Deficiency regulations laid before Parliament.⁹³ L.T. Hilliard expressed similar views, pointing out that it was perfectly normal for someone on licence to want to associate in the same way as the rest of their work colleagues, and to make 'normal emotional attachments'.⁹⁴ We should note from the earlier NCCL quotation the use of the term 'disability' to refer to the effects of licencing. Mental hygienists had touted the licencing system as a humanitarian system of trial, embodying care and control, outside of the segregated institution. This was now revealed as, both emotionally disabling, and potentially causing the 'problems' of sexual licence and propagation that it claimed to be preventing in the interests of the community and the individual.

The NCCL also emphasized that people on licence lived in fear of compulsory and instant return to hospital for transgressions that might not be clear and never explained to them. It noted that any complaints about employment conditions or pay could be labeled 'rudeness' and precipitate return to the institution.⁹⁵ Here again the NCCL applied the term 'subnormal' not to the people so labeled but to the rates of pay that it claimed many of them were forced to endure.⁹⁶ The lack of attention to the

⁹² NCCL, *50,000 Outside the Law*, p26.

⁹³ NCCL, *50,000 Outside the Law*, p26.

⁹⁴ L.T. Hilliard, 'Resettling Mental Defectives: Psychological and Social Aspects', *British Medical Journal*, 12th June, 1954, p1374.

⁹⁵ NCCL, *50,000 Outside the Law*, p25.

⁹⁶ NCCL, *50,000 Outside the Law*, p31.

emotional effects of 'treatment' and 'rehabilitation' were further noted with regard to attempted escapes from institutions. It was argued that little effort was made to appreciate the motives for attempted escape. Indeed, these acts were generally seen as further proof of innate deficiency and often 'treated' by confinement to bed for a week or two, solitary isolation, or an indefinite period on a 'refractory' ward. Commenting on these measures and patients' potential reactions the NCCL remarked:

It is perhaps reasonable to expect that a patient who had escaped and successfully obtained employment and maintained himself until recaptured and who had been brought back to the institution for further care and protection under conditions of seclusion, might feel inclined to do a little damage.⁹⁷

Perhaps the most poignant comment in the NCCL's report was this: 'It should be emphasised that there is never a hearing for a mental defective. A charge, by itself, is sufficient.'⁹⁸ With this comment the NCCL summed up the power of a one-way reason which could brook no response from those it targeted other than through the terms in which it defined them. This professional power, buttressed by coercive legislation, asserted a domination that could not be questioned by those under its control. In this context the NCCL relayed instances of arbitrary censorship of letters, revocation of licence without explanation, and the denial of evidence of 'social competence' which included assurances from employers, trades unions, and even

⁹⁷ NCCL, *50,000 Outside the Law*, p23.

⁹⁸ NCCL, *50,000 Outside the Law*, p25. In this context the case of 'Thomas' was cited. His father had received a letter from the Ministry of Health reminding him that his son had been granted trial on licence in his care for six months, but that whilst on licence he had been charged with stealing a motor vehicle. In consequence, the letter informed him, Thomas' licence on trial had been cancelled. But the letter omitted the crucial fact that Thomas had not been convicted of any offence but given an absolute discharge. As the NCCL remarked. 'He still lost his freedom. He was a mental defective!' (p26).

confirmation of acceptance as a National Coal Board trainee.⁹⁹ Evidence was produced, in particular, to highlight abuses of the system for renewal of certification. This procedure was required to be undertaken every five years. Under the terms of this mechanism reports were to be submitted to the Board of Control by the hospital visitors (usually two doctors and a number of lay magistrates) and the Medical Superintendent at the end of a period of certification. The Board of Control was then to decide whether renewal was required. In conjunction with this procedure the Mental Deficiency Act made specific provision whereby an independent medical report could be obtained, either by the patient themselves, or by friends or relatives. But the NCCL pointed out that the Mental Deficiency regulations did not actually lay down procedures through which friends or relatives could be advised in advance either of the date for renewal, or of their right to the independent examination which the Act specifically provided for. After enquiries made by the NCCL the Board of Control finally replied that there was no statutory procedure whereby a patient could obtain an independent medical examination, but that facilities were 'invariably granted on behalf of relatives or at their insistence.' In response the NCCL remarked: 'It is difficult to know what this statement means, unless it means that a legal right exists, and has existed for 37 years, and the Board of Control is unable to say how it should be exercised!'¹⁰⁰ Indeed the NCCL expressed its general exasperation at the Board of Control's responses to its queries, which regularly failed to actually deal with any of the questions posed.¹⁰¹ It was in such circumstances of little accountability throughout the mental deficiency system, wrote the NCCL, that an 'unconscious bias' towards retaining 'high-grade' patients, rather than discharging them, might prevail.

⁹⁹ NCCL, *50,000 Outside the Law*, p20 and 22.

¹⁰⁰ NCCL, *50,000 Outside the Law*, p14-15.

¹⁰¹ NCCL, *50,000 Outside the Law*, p28-9.

Clearly it was a matter of opinion which types of people were 'maddeningly incapable of giving a straight answer' or personified an 'unreasoning stubbornness' against listening to, or even acknowledging 'the other man's point of view'. And it put into a new light one mental hygienist's assertion, at the International Congress, that one of the tasks of mental hygiene was to work together with social scientists to prevent human beings being 'made to believe and behave in particular ways by the deliberate manipulation of anxiety and fear, and the propagation of prejudice'.¹⁰²

As I have mentioned, despite the public antagonism between the NCCL and NAMH, significant figures who provided support and advice for the civil libertarian campaign also had close connections NAMH. Moreover the ascendance of the problematic of emotional relationships as explanatory of, and therapeutic for, mental disorders, could accommodate civil libertarian views. This attention to the impact and expression of emotional relationships, as I have shown, implied more sensitivity and less overt control coupled to an emphasis on greater liberty, personal possessions, and contact with the outside community. In fact, here, in the early 1950's, we have an exact corollary of the civil rights pronouncement by MIND's director in 1985 that the mental welfare services 'erode self-determination, demolish citizenship, and withdraw power'.¹⁰³ Psychiatry considered mental disorder itself to bring this about. Civil libertarians, in conjunction with some mental hygienists applying the new emotional-relational problematic to the 'problem' of mental deficiency, partially reversed this assumption. But they did so long before NAMH became MIND and adopted a role as a civil rights pressure group. Indeed the conjunction of civil libertarianism and

¹⁰² D. Mitrany, speaking on, 'Problems of World Citizenship and Good Group Relations', *International Congress on Mental Health, London 1948: Volume IV*, p81.

¹⁰³ Christopher Heginbotham, speech to Oldham AMA Conference 27.9.85 p1

mental hygiene through the problematic of emotional relations informed this later strategy.

Chapter Five

Emotions Situated in the Web of Relationships: 3.

Introduction

This chapter is divided into two parts. The first traces out how, in accordance with the programme of the 1948 Congress, mental hygienists attempted to retain their functionalist agenda for the mental health of individuals and society, whilst shifting their attention from notions of individual adjustment to adjusting inter-personal relationships. The second part sets out how this very attention to relationships served to detach mental hygienists' discourse of emotionality from their progressive histories, and functionalist interpretations of the health of individuals and society. As a result, the discourse of emotionality, with its emphasis on socially integrated inter-personal relationships, continued its influence. But mental hygienists' self-appointed expertise and authority was thrown into question. These two connected processes are important because, as we will see, in the following chapter both the discourse of emotionality, and the questioning of expert power, played an important role in the rights strategy adopted by NAMH in the early 1970's.

Part One: Mental Hygiene's Functionalist Agenda Retained.

Mentally Healthy Relational Integration Versus Mentally Unhealthy Isolation.

The discourse of emotionality continued to place primacy on development in infancy – particularly the mother-child relationship - as the central area of socialization. But I show here that, in keeping with much of the wartime work that I have described, mental hygienists increasingly viewed social institutions as 'communities' of interactional relations that were crucial to the maintenance of mental health and social equilibrium. Indeed, the general community itself was viewed as a dynamic network of human relations. As mental hygienists developed this approach through the post-war years they outlined a philosophy which contrasted distorted or impoverished emotional relationships leading to isolation, passivity and mental disorder, with well adjusted emotional relationships that produced mental health and social integration. In sum, the general post war vision of the movement for mental hygiene was one of combating unhealthy relational isolation through the creation of healthy relationships, which would thus enable social integration and harmony.

The 1948 Congress had described the essentials of mentally healthy personhood in emotional and relational terms. Theirs was not an image of the contractual isolated individual of political science but of beings whose emotional and relational inter-

dependence required expert guidance for their own and society's 'healthy' functioning. Mental hygienists carried this vision with them in their post-war activities. With their reconfigured attention to emotional development framed in terms of interacting relationships, mental hygienists had started to trace the aspects of maturation away from the internal economy of the individual and outwards to the dynamic social and relational domain. But, though mental hygienists were, as we have seen, increasingly situating mental troubles and their therapy in terms of a web of dynamic emotional relationships, theirs was often a limited notion of the social matrix. The foundation for their re-conceptualization remained the emotional biography of the developing child within the family. The principal and primary socializing environment remained the mother-child relationship. With this there continued to be a tendency, in some areas, to relegate the wider family, the neighbourhood, the school, and the community, to the role of secondary and successive arenas of socialization.¹

After the war and throughout the 1950's influential psychoanalysts such as D.W. Winnicott and John Bowlby promoted mental hygiene on the basis of the expert guidance of emotional development centered around infancy and childhood. Indeed, Winnicott continued to echo the grand schemes proclaimed as the mission of mental hygiene at the 1948 congress. For him, mental hygiene was not only a public health measure, but also a means to alter the kind of people who populated the world.² His descriptions of the importance of the mother-infant emotional couplet mirrored Bowlby's extremely influential work on maternal separation. In 1952 Bowlby

¹ See, for example, G.R. Hargreaves, speech at *Mental Health and Personal Responsibility: Proceedings of a Conference held at Royal Hall, Harrogate 12th and 13th April, 1956* 19-26, p23-25; E. Mildred Creak, 'Recent Advances in Child Care', at a NAMH Conference on, *The Practical Application of Research and Experiment to the Mental Health Field* (London: NAMH, 1953) 63-73.

² D.W. Winnicott, 'The Foundation of mental Health', *Lancet* 16th June, 1951, reprinted in *Deprivation and Delinquency*, Clare Winnicott, Ray Shepherd and Madeleine Davis (eds) (London: Tavistock, 1984) 168-171, p168.

published a report sponsored by the World Health Organization on *Maternal Care and Mental Health*.³ In it he synthesized earlier work on the effects of institutional care on children (most of it psychoanalytical) and offered his own conclusions about the long-term consequences of maternal deprivation for individual character and social life. Evidence that such deprivation caused 'affectionless characters' and delinquency constituted, he argued, a discovery comparable to that of the role of vitamins for physical health. He claimed that this had 'far-reaching significance for programmes of preventive mental hygiene'.⁴ NAMH celebrated the publication of this report as vindication of mental hygienists' knowledge about the factors that produced 'mental and emotional ill health' and of the need to disseminate this knowledge to the community.⁵ A six-page review in its journal reveals the key linkage between therapeutic attention to emotionality and normative histories of individual and community development. The review noted that Bowlby's report would be:

...worth reading simply for the conclusion alone that the proper care of children deprived of normal home life is not only humane but essential for the well-being of the community. For these children, by reproducing their problems, act indeed as "carriers" of their disease in our midst.⁶

Between the wars mental deficiency, as a testament to arrested evolution, had been reified as a social contagion with a 'tendency to perpetuate itself by creating an environment inimical to the development of normal mentality'.⁷ Now, as had been

³ John Bowlby, *Maternal Care and Mental Health* (Geneva: WHO, 1952).

⁴ John Bowlby, *Maternal Care and Mental Health*, p13-14.

⁵ NAMH, *Annual Report 1951-2*, p8-9.

⁶ 'Maternal Care and Mental Health', *Mental Health* 11 No.2 Spring 1952 70-75, p74.

⁷ Report of the Departmental Committee on Sterilization, cited in, 'Report of the Departmental Committee on Sterilization', *Mental Welfare* 15 1 (1934) 1-7, p7.

outlined at the International Congress in 1948, the 'science' of human relations focused on a newer history; the history of emotional development. Emotional relations were now the key to promoting the health of the individual and of the social order.

A few years later NAMH published a pamphlet written by Bowlby giving advice to mothers on the question, *Can I Leave My Baby?*⁸ The very title of the pamphlet suggested that any sort of separation needed careful thought and was potentially dangerous.⁹ Bowlby reiterated mental hygienists' claims that their knowledge was only a scientific confirmation of what 'good' mothers and fathers had always known.¹⁰ NAMH had provided similar advice to mothers on the emotional development of children in a series of publications produced since the 1940's.¹¹ These publications focused on the subtle qualities of the relationship between mother and child, and continued to emphasize that modern psychological knowledge had shown that, just as children's bodies were weakened by poor diet and physical conditions, so their personalities could be damaged by either inadequate or inappropriate affection.¹²

Combined with these theorizations was the retention of a more general historical description of the past as consisting of hierarchical stages of progressive development.

⁸ John Bowlby, *Can I Leave My Baby?* (London: NAMH, 1958).

⁹ It might be noted here that Bowlby linked his particular interpretation of the discourse of emotionality to ethology as well as psychoanalysis. It was thus closely built around an evolutionary biological history which allowed Bowlby to contend that: 'Any moves that separates children from their mothers needs scrutiny, for we are dealing here with a deep and ancient part of human nature.' John Bowlby, 'The Formative Years', talk for the BBC, 1968, cited in Denise Riley, *War in the Nursery*, p107-8.

¹⁰ John Bowlby, *Can I Leave My Baby?*, p5; D.W. Winnicott, 'The Foundation of mental Health', p169.

¹¹ Through the 1940's and 1950's the NAMH published a 'Parent Guidance Pamphlets' series in which the key phases of child's emotional development were outlined and their importance for emotional adjustment emphasized. These were by; Winifred Coppard, *Breast Feeding*; by Josephine Guy, *Young Children and Play*; and by Ruth Thomas, *Habit Training; Further Trying Habits; Children Who Dislike Their Food; Temper Tantrums; Childrens Fears; Fears and Jealousies*.

¹² NAMH, *Do Babies Have Worries?* (London: NAMH, 1953), p1.

The discourse of emotionality continued to be founded upon this wider evolutionary history. As we have seen, mental hygienists had, between the wars, concentrated on moulding the emotional economy of personhood in order that individual and societal health could be attained. Emotional adjustment was gauged by means of a set of historical stages of development. These norms provided the dynamic interface between the perceived requirements of healthy adjustment and the 'needs' of society. To pass through them satisfactorily was to mature to satisfactory personal adjustment and responsible citizenship. To divert too far from them was ultimately to threaten not only one's own health but also that of society. Post war, and in line with the 1948 International Congress, mental hygienists re-built their functionalist programme for 'healthy' efficient individuals in a 'healthy' efficient society in terms of inter-personal relationships. G.R. Hargreaves, for instance, emphasized in the 1950's that until recently the promotion of mental health had been based around the concept of adaptation to society. This, he maintained, was now considered a one-sided approach that paid little attention to the nature of the environment and whether adaptation to it would in fact promote mental health.¹³ But Hargreaves nevertheless went on to describe the promotion of mental health in the functionalist terms of responsible social participation.¹⁴

The Historical Register Retained.

The continued functionalist imperative incorporated the notions of 'primitive' and 'civilized' associated with mental hygienists' descriptions of societal evolution. But these were now re-worked in terms of progressive human relationships. Douglas

¹³ G.R. Hargreaves, speech at, *Mental Health and Personal Responsibility: Proceedings of a Conference held at the Royal Hall, Harrogate 12th and 13th April, 1956*. 19-29, p20-21.

¹⁴ G.R. Hargreaves, speech at, *Mental Health and Personal Responsibility*, p23-26.

MacCalman, for example, drew on the historian Arnold J. Toynbee's mammoth work *Study of History*. Toynbee was a classicist whose work dealt with the growth and decay of civilizations. MacCalman remarked in a speech to psychiatric social workers that:

What surprised and interested me was that he is concerned with the same sort of problem in human relationships as we are, though he thinks in terms of civilizations and we in terms of generations.¹⁵

MacCalman latched upon Toynbee's general conclusions that civilizations emerged in response to adverse conditions, to recapitulate the kind of Social Darwinist views that had been deployed by mental hygienists between the wars. Thus he quoted approvingly an anthropological account, written fifty years earlier, of the people of Nyasaland in Africa as living in 'native simplicity'; 'Primeval Man, without clothes, civilization, learning, religion – the genuine child of nature, thoughtless, careless and contented.'¹⁶ For MacCalman the challenge of difficult environments, in contrast, encouraged the growth of civilization, and likewise the challenge of 'interpersonal relationships' encouraged the individual effort of adjustment to attain inner harmony.¹⁷ Other mental hygienists placed greater emphasis on promoting more harmonious inter-personal relationships. In an article promoting the programme of mental hygiene, Kenneth Soddy advised that the 'health of the community' could not be gauged from the sum of the mental health of its individual members. Instead, the criterion of individual mental health, 'harmonious living', should be applied to society. The social body must live in harmony with itself. The study of community health,

¹⁵ D.R. MacCalman, 'Sweet are the Uses of Adversity', *British Journal of Psychiatric Social Work* No.3 November 1949 87-94, p87.

¹⁶ D.R. MacCalman, 'Sweet are the Uses of Adversity', p90.

¹⁷ D.R. MacCalman, 'Sweet are the Uses of Adversity', p94.

Soddy enjoined, was 'of vital importance' and 'firmly rooted in culture and history'.¹⁸ Holding to a similar conceptualization, the senior Tavistock psychiatrist H.V. Dicks, placed particular emphasis on family relationships. He contended that, on the one hand the modern 'atomised urban family' represented the 'pint pot' into which had to be compressed all the intimate human relationships once contained by the wider traditional kinship group. But on the other hand, this family held the potential for 'levels of maturity and breadth of personality well above the closely regulated social limits of olden days.'¹⁹

This prescriptive image of history as progressive stages of development, with the mental health of individuals and society critically related to it, informed NAMH's post-war activity. This is clear in NAMH's continued promotion of psychiatric social casework in the community. After the war the Ministry of Health decided to discontinue funding the SACS in the face of the 1948 National Health Service Act, which placed the power (though not the duty) to provide after-care for people suffering from mental illness under the remit of local authorities.²⁰ Despite this NAMH continued to support experimentation and push for its development. In a speech at a NAMH conference on 'Community Mental Health' in 1951 the psychiatrist T.A. Ratcliffe, who was closely involved with this work, explained that: 'The concept of mental health in a community would seem to demand two things – that individual members of that community should be themselves stable, secure and settled and that

¹⁸ Kenneth Soddy, 'Mental Health', *International Health Bulletin of the League of Red Cross Societies*, 7 No.2, April-June, 1950, 8-13, p10.

¹⁹ H.V. Dicks, 'Strains Within the Family', NAMH, *Strain and Stress in Modern Living: Special Opportunities and Responsibilities of Public Authorities* (London: NAMH, 1954) 28-37, p31.

²⁰ NAMH, *Annual Report 1948-1949*, p11-12.

the community pattern itself should be a mentally healthy one.²¹ As before the war, deviations from generally accepted social norms and definitions of contemporary social problems continued to be interpreted in terms of mental health. For Ratcliffe, the 'problem group' encompassed by the 'socially maladjusted' and the 'social misfit' represented a barometer of the mental health of the community. This group included the, 'delinquent, the chronic absentee from industry, the problem family, the solitary and inadequate personality type', as well as, 'chronic minor ill-health, divorce, child neglect, and other similar problems'. These, he asserted, were the targets of the 'expert in mental health.'²²

But Ratcliffe conjoined this with the newer mental hygiene conceptualization of emotional health and adjustment as founded in the dynamics of inter-personal relationships. The 'one common factor of all socially maladjusted people', he explained, was an inability to form 'adequate stable or satisfactory human relationships with others in their environment'.²³ Traditional psychiatric services were, he maintained, woefully inadequate, and indeed had not developed to deal with such problems. A true community care service should therefore constitute a service of 'relationship therapy.' .

Community case-work was conceived as providing an 'educative process towards mature independence.'²⁴ The psychiatric social worker was to take on the leading therapeutic role in this. Therapeutic procedure was directly related to the dynamic

²¹ Ratcliffe, T.A., Speech at conference on 'Community Mental Health in Practice', NAMH, *Proceedings of a Conference on Mental Health held at St. Pancras Town Hall, London, N.W.1, 12-13th March, 1951* 11-23, p11-12.

²² Ratcliffe, T.A., Speech at conference on 'Community Mental Health in Practice', p12 and p13.

²³ Ratcliffe, T.A., Speech at conference on 'Community Mental Health in Practice', p14.

²⁴ Ratcliffe, T.A., Speech at conference on 'Community Mental Health in Practice', p14.

relationship of a child and its mother in the process of emotional development to maturity:

... just as the parent-child relationship should be the epitome of future relationships for the child and the path which leads him to adult maturity and independence of personality, so the client- Psychiatric Social Worker relationship should be an experience which leads the client on until he can form his own mature adult relationships in his environment.²⁵

Ratcliffe maintained that the social worker must provide a sympathetic and understanding bond with the client. Through this careful work it was hoped a stable relationship would slowly emerge. Associated with this emphasis, psychiatric social workers began to develop the concept of a 'holding' role towards the feelings of the patient.²⁶

Reorienting Relationships for Social Adjustment and Integration.

Whilst those promoting such a social casework service were conceiving generally defined categories of contemporary social problems as aspects of emotional immaturity and attempting to provide a nurturing relationship in which growth to maturity could take place, others were directing their attention to the wider matrix of emotional development. In 1949 Bowlby published an article entitled *The Study and*

²⁵ Ratcliffe, T.A., Speech at conference on 'Community Mental Health in Practice', p14.

²⁶ See, for instance, Pauline, C. Shapiro, 'From After-Care to Community Service (London: NAMH, May 1949) (pamphlet), p9-10.

*Reduction of Group Tensions in the Family.*²⁷ In it he contended that child guidance should not be concerned solely with the treatment of the child brought to the clinic but with the whole family structure. Bowlby described the family as a 'structured group of a kind not dissimilar in its nature and dynamics from any other structured group, for instance a factory group'. It is noteworthy that he acknowledged the connection of this work, both with 'human relations' theories applied to industry, and group work with adults in mental health.²⁸ Indeed, the terminology used in the title of his paper, is precisely the same as Bion and Rickman's wartime paper on the therapeutic community experiment at Northfield; theirs had been called, "Intra-group tensions in therapy: their study as the task of the group'.

It was on the basis of this approach that the traditional title of 'child Guidance' was dropped by the Tavistock's Children's Department in the early 1950s. Dugmore Hunter, the consultant psychiatrist at the clinic, maintained that the word 'guidance' was misleading since it suggested an emphasis simply on the child, as well as a notion that the clinic just dispensed advice in a didactic way.²⁹ Hunter noted that many others were similarly discarding the term. 'Old' notions of child guidance were giving way to approaches that problematised the emotional and relational interactions of family members. Hunter emphasized the importance of psychoanalytical approaches to these changes. He maintained that the investigation of unconscious motivations in individuals had been a relatively recent phenomenon in child guidance. More recent

²⁷ John Bowlby, 'The Study and Reduction of Group Tensions in the Family', *Human Relations* 2 No.2 1949 123-128.

²⁸ John Bowlby, 'The Study and Reduction of Group Tensions in the Family', p123 and 124.

²⁹ Hunter, Dugmore., 'An Approach To Psychotherapeutic Work With Children and Parents', *11th Inter-Clinic Conference For Staffs of Child Guidance Clinics: 'The Family Approach to Child Guidance-Therapeutic Techniques'*, (London:NAMH,1955)11-26, p12. The Tavistock called it's clinic The Department of Children and Parents.

still, he noted, had been the development of these procedures to take into account the relational group:

The old basic questions such as, 'What is the diagnosis in this child's case and what are the aetiological factors, in terms of heredity and of environment?' have taken a slight twist and emerged in a new form. We find ourselves looking at the family as a living organism in which there are complex patterns of interplay between the members, continuing but yet shifting, in an intricate self-balancing way, so that change in one member provokes reaction and adjustment in each of the others. And so we find ourselves asking, what are these people doing to each other, and why?³⁰

Both this child guidance attention to the family as a dynamic interactional group, and the psychiatric casework emphasis upon a nurturing relationship between therapist and client, informed other experiments in community work promoted by mental hygienists. From 1955 NAMH was involved in the Shoreditch Project. This was an experimental project in 'preventive mental health work' in the community. The practical aim was to provide social-case work to families where children's school behaviour was believed to be indicative of difficulties in the home. The more general initial aim was to contribute to the 'study of the causes of delinquency, maladjustment, unhappiness and family breakdown'.³¹ Casework support for the families was founded on the assumption that that the social problems experienced were directly related to the quality of relationships within the family.

³⁰ Hunter, Dugmore., 'An Approach To Psychotherapeutic Work With Children and Parents', p12.

³¹ NAMH, Annual Report 1954-1955, p15; CMAC, Robina Adiss archive, PP/ADD/D.19.

The functionalist imperatives are distinct here. Work with families employed the functionalist sociologist Talcott Parsons' theories of social role and the family structure. Parsons' description of the role of the modern western family fitted easily with mental hygienists' views. He considered it to be the principal institution of socialization, adjustment and stabilization of individual personalities for the social system. This role he cast as a historically specific aspect of a broader historical process of societal evolution from simple to complex forms.³²

In the Shoreditch project the family, rather than the individual became the centre of investigation and therapy. The aim was to restore the 'equilibrium' of family relationships by helping family members to adapt their 'role performance'.³³

Therapeutic work with families incorporated group work. Groups for children were founded on the principle that distorted family relationships had disrupted a child's progress through certain developmental stages. The 'emotional climate' provided in group sessions was considered to provide an environment in which these stages might be worked through.³⁴

This concentration upon the quality of inter-personal relationships, as a crucial arena in which healthy mental development or emotional maladjustment became manifest, was echoed across other sites of mental hygiene work. NAMH developed a number of experimental residential homes for children and young adults through the 1950's and 60's that embodied this conceptualization. For instance, it opened 'Fairhaven', a

³² Talcott Parsons, *The Social System* (New York: The Free Press, 1951); Talcott Parsons, 'The Social Structure of the Family', in R.N. Anshen (ed), *The Family: Its Functions and Destiny* (New York: Harper and Row, 1959).

³³ Michael Power, 'Casework in the Shoreditch Project', *British Journal of Psychiatric Social Work* 5 No.1 10-18, p16.

³⁴ Madge Hamilton, 'Groupwork with Children in a Family Agency', *British Journal of Psychiatric Social Work* 5 No.2 1959 75-83, p76.

hostel for 'Educationally Subnormal' (ESN) school leavers at Blackheath, South London in 1958.³⁵ Fairhaven represented, in part, an attempt to provide therapeutic care in a 'community home' for teenagers who might otherwise have been sent to mental deficiency hospitals.³⁶ Although measures of intelligence were still employed by psychologists at Fairhaven, increasingly 'social maladjustment' became the main focus of attention. The Hostel's main function was to attempt to correct, or compensate for, what were considered to have been the faulty human relations of earlier home life and distorted relations experienced in boarding schools. The negative effects of institutional life on intellectual and practical capabilities were recognized. NAMH particularly emphasized the need to undo this 'institutionalism' through providing opportunities for boys to master the day-to-day practicalities of life. Boys were assisted with dealing with public transport, handling money, and coping with forms and documents. But also emphasized were the debilitating effects of institutionalism and distorted relationships on emotional development and well being. These children were understood to have been denied the healthy expression of emotions and starved of affection. It was therefore accepted that they were unable to develop adequate relationships with either their peers or older people.³⁷ At Fairhaven children who displayed 'attention seeking behaviour' were less likely to have this seen as an innate trait of their condition. Rather, they were understood to be exhibiting the consequences of poor and distorted relationships earlier in their lives.

Other residential ventures took the form of therapeutic community style work.

NAMH supported several innovative workers who made their names developing these

³⁵ 'Fairhaven', *Mental Health* 19 3 (Autumn 1960) p98-101.

³⁶ Page, Ian., 'Hostels for Educationally Sub-Normal Adolescents: An Experiment in Rehabilitation', *British Journal of Psychiatric Social Work* (1960) 22-25, p25.

³⁷ 'Fairhaven', *Mental Health* 19 3 (Autumn 1960) p98.

approaches to residential care. These included Richard Balbernie who ran a school for maladjusted children who were considered educationally 'backward'.³⁸ His work was highly regarded by NAMH.³⁹ Balbernie went on to develop therapeutic community style work at the Cotswold Community, an approved school for maladjusted children.⁴⁰ Here he developed methods employed by another well-known childcare innovator, Barbara Docker-Drysdale, who had herself been supported by NAMH.⁴¹

Similarly oriented work was developed at Reynolds House, which NAMH opened in 1963. This aimed to provide a half-way home for boys from schools for children labeled maladjusted. Its warden, David Wills, had been the first psychiatric social worker to train in the United States and was well known, and respected, for his work in progressive education.⁴² As elsewhere, the emphasis of care was on the reorientation of emotional relationships in order to produce healthy growth and adjustment. Wills maintained, for example, that a residential school for maladjusted children could be deemed to have been successful in as much as a child had learned to relate at it.⁴³ Reynolds House also continued the wartime emphasis on the need for family style care. Wills and his wife provided the married couple whom, it was hoped, would provide the stable atmosphere and continuity of relationship necessary for children's social adjustment.⁴⁴

³⁸ S.K. Brindley and G.H. Pettingale, 'Swalcliffe Park School', *Mental Health* 22 No.3 August 1963 112-114.

³⁹ NAMH, Minutes of Council meeting 31st October 1952, para 7.

⁴⁰ Richard Balbernie, *Residential Work with Children* (Oxford: Pergamon, 1966).

⁴¹ Maurice Bridgeland, *Pioneer Work With Maladjusted Children* (London: Staples Press, 1971), p277.

⁴² His best known work is that of the Hawkspur Camp. This was a pioneer residential camp for young delinquents set up in 1936. See, David Wills, *The Hawkspur Experiment* (London: George Allen & Unwin, 1941), also David Wills, *The Barns Experiment* (London: George Allen & Unwin, 1945).

⁴³ David Wills, *Reynolds House: A Report on the First Five Years* (Unpublished Manuscript, April 1969), p35.

⁴⁴ David Wills, *Reynolds House: A Report on the First Five Years*, p4-5

The same prioritization of relational dynamics continued to influence mental hospital experimentation. In part, these post-war approaches were associated with what was known as the 'open door' movement that spread across a number of mental hospitals during the 1950's. One important figure in this was T.P.Rees.⁴⁵ He had long been involved with NAMH and its precursor organizations. In 1957 he was appointed a member of its medical panel.⁴⁶ His work was considered an example of the developing concept of the hospital as a therapeutic community. Rees believed that:

Patients come to mental hospitals in order to learn how to live with other people, and to do that successfully they can reasonably be expected to contribute something to the welfare of the community in which they live. The role of the patient as an active member of the hospital team, promoting his own recovery through his contribution to the work of the hospital as a whole, brings us to the concept of the mental hospital as a therapeutic community, as an instrument of treatment in its own right. We, as doctors, are apt to flatter ourselves by attaching undue importance to specific methods of medical treatment. From the patient's point of view it is the total picture that counts, not the daily, weekly, monthly or six monthly hour he spends with his doctor that matters so much as what happens to him in between these periods.⁴⁷

⁴⁵ The *Lancet* published an article in 1953 on the 'Open Door' hospital experiments at Mappesbury, Nottingham, and Warlingham Park Hospitals; 'Freedom in Mental Hospitals', *Lancet* November 6th, 1954 964-6; 'The Unlocked Door' (Leader) *Lancet* November 6th, 1954 953-4.

⁴⁶ NAMH, Annual Report, 1957-8, p3.

⁴⁷ Cited in , 'The Mental Hospital as a Therapeutic Community', paper by T.M. Cuthbert in, NAMH, *The Needs of the Mentally Sick: A Challenge to Youth: Report of a conference held on 17th October 1957* (London: NAMH, 1957) 3-14, p13-14.

T.P. Rees co-authored a World Health Organization report on mental health in 1953.⁴⁸ This viewed the patient as the central point of social relationships that formed within wider society rather than, an 'isolated individual, inside whom things are happening'.⁴⁹ Admission to hospital represented desocialization and failure of human relationships. The report promoted a concept of the mental hospital as a 'therapeutic community' that should attempt to preserve patients' individuality and promote activity, responsibility and freedom, in order to reverse desocialization and promote interpersonal emotional relations. Rees believed that, 'the condition of the patients in mental hospitals is often the result of the conditions under which they are treated, rather than the symptoms of a disease process.'⁵⁰

Moral Therapy Continues.

Across the sites of mental hygiene then, was manifest this conceptualization of the need for re-socialization through the nurturing and creation of relationships of a certain quality. At all of these cites the central problem to be resolved was construed as distorted or impoverished relationships. The process of therapy itself was considered to be one of promoting more 'healthy' relationships. But, this conceptualization of relationships could, and often did, result in an approach that assumed the therapists themselves to be outside the frame of reference. In effect the discourse about mental disorder could easily remain the moral therapy one, described

⁴⁸ WHO, *Third Report of the Expert Committee on Mental Health* (Geneva: WHO, 1953).

⁴⁹ Taken from D.H. Clark's description of the focus of this report in, D.H. Clark, 'Functions of the Mental Hospital', *Lancet* November 17th 1956, 1005-1009, p1008.

⁵⁰ T.P. Rees, in a review of M. Greenblatt, R.H. York and E.L. Brown, *From Custodial to Therapeutic Care in Mental Hospitals* (New York: Russell Sage Foundation, 1955) in *Mental Health* 16 3 Summer 1957, p113.

by Roy Porter, of simply investigating how people considered to have mental troubles responded to treatment.⁵¹ This allowed the conduct and assumptions of therapists and staff, along with the method of treatment itself, to remain unconsidered.

For example, at some hospitals, promoting what was considered to be a therapeutic community philosophy, patients were placed in a hierarchy of grades according to their perceived ability for social and emotional interaction.⁵² At Rees' Warlingham Park hospital this approach entailed that incontinent patients were 'habit trained' through rigid discipline and tables of promotion and demotion.⁵³ This emphasis upon teaching the patient new ways of reacting tended to place the focus away from questioning the roles and attitudes of staff or aspects of the patient's wider relations on discharge. The tendency of this approach to be un-reflective encouraged the continuation of an attitude of moral guidance blind to its own prejudices. Describing the employment of Warlingham nurses in the after-care of discharged patients, for instance, T.P. Rees relayed the following 'success' story:

I can well remember one man telling me his wife was no better and would have to come back into hospital. I had a suspicion that he had his eye on another woman and told him his wife was perfectly all right. Next week he came back and said she was dreadful at home, she would not do a thing in the house. So I talked to the ward sister who was working outside the hospital and she said "That woman was on the ward with me; she had a leucotomy [lobotomy] and helped look after the ward kitchen; she was magnificent and

⁵¹ Porter, Roy, 'Shaping Psychiatric Knowledge: The Role of the Asylum' in, Roy Porter (ed) *Medicine in the Enlightenment* (Amsterdam: Clio Medica, 1995) 255-273, p269.

⁵² T.M. Cuthbert, 'The Mental Hospital as a Therapeutic Community', p10-11.

⁵³ Clark, D.H., *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996) p89.

kept the kitchen spotlessly". When the ward sister went to the house about 9.30 a.m. next day she found nothing had been done since the husband had left; there were half-used milk bottles on the table and the beds had not been made. So she sat down as a good mental nurse does and told the patient to get on with the work, which of course she did. After that the ward sister looked in about once a week; the patient never knew when she was coming. There were no more complaints from the husband!⁵⁴

Similarly unreflective views, that were often gender or class biased, were expressed elsewhere in residential care.⁵⁵ Such attitudes could also be distinct in some areas of child guidance clinic work. One example is the trend amongst child guiders in the 1950's to diagnose and treat a particular type of school truancy, which they termed 'school phobia'.

In 1959 a child guidance conference dedicated to the subject agreed that 'school phobia' was a condition that, though related to truancy, was quite distinct from it. One leading child psychiatrist embodied the general consensus by describing truancy as; 'on the whole a *social* problem ... arising in bad homes, with inadequate care; hence from somewhat lower strata than the school phobic.'⁵⁶ A child guidance psychologist remarked similarly that, 'truants mostly come from poor homes, and have on the whole, rather less than average intelligence'.⁵⁷ School phobics were, in contrast,

⁵⁴ T.P. Rees, discussion at conference on, *The Needs of the Mentally Sick: A Challenge to Youth*, p62.

⁵⁵ See, for instance, H.C. Gunzburg, *Social Competence and Mental Handicap: An Introduction to Social Education* (London: Croom Helm, 1968), p119, in which he suggests that these young people's residential home surroundings should prepare them for 'the realities of a modest and unassuming existence'.

⁵⁶ C.L.C. Burns, 'Conference "Summing Up", *Truancy or School Phobia? Being the Proceedings of the 15th Intra-Clinic Conference* (London: NAMH, 1959) 26-32, p26. See also report on the discussion groups at the conference, p34.

⁵⁷ J.L. Green, 'Truancy – Or School Phobia', *Truancy or School Phobia?* 8-16, p11.

generally from materially good home backgrounds, with either average or above average intelligence, and of a sensitive nature. But attitudes towards these latter children were no less normative and unreflective than those towards the, apparently distinct and lower class, truants. Most truants and 'phobics' were boys. The 'phobics' were described as having 'feminine' characteristics, and often fixated on their mothers who were considered to be frequently over-protective.⁵⁸ Physical characteristics were correlated with these 'feminine' psychological attributes. One child guider remarked that, in his experience; the boys tended to be 'characteristically aesthenic with pale, translucent skin, large protruding ears and a tendency to rabbit teeth.'⁵⁹ The mothers were apparently, 'as might be expected ... all "neurotic" in some sense or another.' As another speaker put it, 'you all know the kind of mothers that one meets in these cases'.⁶⁰ The fathers were variously; aloof, distant, 'almost maternal, too involved in the family', submissive, inadequate, 'rather interfering, assertive or irritable', or 'unstable'. One wonders who might not fit one of these descriptions sometimes. But apparently to the psychiatrist who supplied these details, out of a sample of 64, this left 'only about 6' that he 'could honestly describe as anything like normal'.⁶¹

These boy 'school phobics' were described at the conference largely in terms of the psychoanalytic version of the prevailing discourse of emotional development. Thus the children's particular emotional histories tended to be seen as stuck at the oedipal stage.⁶² As to the reason why there were apparently such a number of school refusers,

⁵⁸ *Truancy or School Phobia?*, p11, 18, 29.

⁵⁹ J.L. Green, 'Truancy – Or School Phobia', p13. See also C.L.C. Burns, 'Conference "Summing Up"', p29 for similar assertions.

⁶⁰ C.L.C. Burns, 'Conference "Summing Up"', p29.

⁶¹ C.L.C. Burns, 'Conference "Summing Up"', p29.

⁶² For instance, E.M. Mason, 'Truancy – Or School Phobia?', *Truancy or School Phobia?* 17-25.

one posited that the general population had become 'softer and more neurotic'.⁶³ Another argued that 'parents have discarded an authoritarian role without always reaching the maturity ... needed for replacing the traditional family pattern with something as strong' According to him, children were not learning the self-discipline necessary to save them from self-indulgence.⁶⁴ But, astonishingly, neither the speakers nor the reports of the group discussions (which comprised 20 groups) actually questioned whether the situation at the school itself could be the primary factor. Nor was it questioned whether any particular child might have perfectly reasonable grounds to want to avoid school. And beyond these particular child guiders comprehension was any idea that the 'norm' of compulsory schooling might itself be questioned. It was taken for granted, in true functionalist fashion, that schools were a functional pre-requisite of full 'socialization' in society. To avoid school was, almost by definition, not only to show inadequate socialization in the family, but also to compound this by attempting to avoid the final significant institution in society that might bring about appropriate socialization. The norm was to go to school and thus the 'illness' was to seek to avoid it, and the 'treatment' to get a child back there. These child guiders, therefore, focused almost exclusively on the 'disturbance' of the child and his emotional interactions at home. 'School phobia' was seen as a symptom of these deeper problems. Such child guiders did not, then, question their assumption of the primacy of the family and the parent-child emotional relationship in the teleology of socialization to maturity. Nor did they question the apparently self-evident function of secondary socialization performed by school attendance.

⁶³ C.L.C. Burns, 'Conference "Summing Up", p27.

⁶⁴ J.L. Green, 'Truancy – Or School Phobia', p15.

But the very situating of mental problems and their therapy, in the dynamic relationships between people, in fact began to undermine the histories of progressive development on which mental hygiene had been built. In the following section I describe some of the ways in which this took place.

Part Two: The Undermining of Mental Hygiene.

History, the backbone to mental hygiene, fragments and transforms.

For me experience is something that I have *lived through*. The trouble with this is that I can have different understandings of the same experience and it is almost as if the experience changes with these different understandings.⁶⁵

Delineations of history had always provided an authoritative backbone for cementing mental hygienists' normative prescriptions for mental health with prescriptions for social citizenship. But considering emotionality and mental health to be a dynamic relational phenomena undid this means of equation. This is important because, what I want to emphasize is that whilst mental hygienists' continued with their conceptualization of emotional relationships as central to mental health and disorder, mental hygiene's functionalist agenda became subverted.

This took effect in various ways. In part conceptualizing mental health and disorder in terms of dynamic relations disrupted 'fixed' notions of an internal disease process.

⁶⁵ Comment of present day mental health service user., cited in Peter Beresford, *It's Our Lives: A Short History of Knowledge, Distance and Experience* (London: Citizen Press, 2003), p37.

In turn it disrupted associated medicalized categories such as 'delinquency', 'feeble-mindedness' or 'imbecility'. This made the boundaries between pathology and normality appear blurred. I do not mean this simply in the sense of the notion of borderline, or borderland 'cases'; such conceptualizations had been expressed during the latter nineteenth-century. Mental hygienists' inter-war deployment of the notion of maladjustment encompassed these views. What I mean is that this ambiguity extended to the boundary between the 'normal', 'mentally healthy' therapist or staff, and the 'ill' or 'maladjusted' patient. This became unclear and thus open to question. In turn, this made normed stages of development to mentally healthy 'maturity' appear unclear. A further factor was that attention to the qualities of emotional relationships tended to take precedence over, and subordinate the progressive histories of mental and societal development, on which their delineation had been founded. These effects took place across the sites of mental hygiene. I trace some of them out in this section.

A Blurring of the Pathological and the Normal.

A paper on delinquency given by John Bowlby in 1949 exemplifies some of these effects.⁶⁶ Bowlby's work has been rightfully criticized for appearing to promote a gender biased medicalization of social problems.⁶⁷ But there are other elements to his work that are significant. We saw in chapter three that the analysis of emotional relationships placed into question some of the social norms about juvenile delinquency which mental hygienists had originally sought to inculcate in the name of 'correct' mental adjustment. Mental hygienists' reconceptualization of delinquency had continued to place aetiology on a perceived lack of parental responsibility by lower class parents. But it had also partially refocused responsibility for delinquency away from the delinquent him or herself and towards the interactional realm where the emotional security considered to prevent delinquency was constructed. Bowlby's 1949 paper continued this attention to the relational aspects of delinquency.

In the appendix to his paper Bowlby outlined what he saw as three false assumptions that had vitiated research into delinquency. These were: That delinquency was a category distinct from other types of behaviour. That all cases of delinquency were essentially similar. And that delinquency could be studied adequately by dealing only with cases referred through the courts. He pointed out, with regard to the first, that there was a spectrum of law-abidingness ranging from the behaviour of the most conforming citizens to the most serious delinquency. He continued:

⁶⁶ John Bowlby, 'The Field of Future Research', NAMH, *Why Delinquency? The Case for Operational Research: Report of a Conference on the Scientific Study of Juvenile Delinquency held at The Royal Institution, London, on 1st October, 1949* (London: NAMH, 1949) 29-43.

⁶⁷ For example, Denise Riley, *War in the Nursery: Theories of the Child and Mother* (London: Virago Press, 1983)

Even if few of us are black, there are many of us who are perhaps not wholly white. A pale shade of grey might characterize many of us. This view is perhaps less agreeable than believing that we are white and the subjects of our study black, but it is certainly nearer the truth and certainly more likely to lead to good research.⁶⁸

With reference to the second consideration, and following on from his first point, Bowlby pointed to the fact that the motivations and reasons for delinquency varied. He maintained, however, that these could be divided into two relevant criteria for investigation: Those relating to the individual's personality and his or her ability to make relationships with others; and those relating to the social structure of the community and its ability to make relationships with the delinquent. As he pointed out, such an understanding had far reaching implications. His recognition that court appearance was not a scientific designation of delinquency led him to argue that enquiry should be extended to 'all cases of unco-operative and anti-social behaviour wherever found'.⁶⁹ He acknowledged that this approach would call into question the behaviour of citizens previously regarded as 'good' since they obeyed society's laws. This was not simply an unreflexive extension of the psychiatric ambit however. His recognition lead him to emphasize the necessity of questioning and investigating the roles of adults with authority over children. This emphasis on the role of human relationships in the development of delinquency thus brought into question here, those who had previously been considered to simply impart moral education and guidance. It mirrors much of the criticism of staff attitudes and conduct developed by NAMH in

⁶⁸ John Bowlby, 'The Field of Future Research', p41.

⁶⁹ John Bowlby, 'The Field of Future Research', p42.

regard to childcare during the war. Moreover, with Bowlby's interpretation, we have clear antecedents to later sociological interactionist 'labeling' theories. Bowlby noted: 'It takes two to make a delinquent as it does to make a quarrel'.⁷⁰ He maintained that there was a 'serious need' to reformulate delinquency research in order to take account of these 'hitherto neglected' factors.⁷¹

In terms of the histories that underpinned mental hygienist authority, what Bowlby in effect did here was to introduce a large element of contingency. The division between the normal and the pathological was here unclear. Thus interpreting normed stages of development and deviations from them also became less clear. Bowlby ignored the further conclusion, however, that if most of us were shades of grey then the question might be better put: Why do some people get labeled delinquent and others not?

Nevertheless, this prioritisation of the therapeutic relationship embedded within a matrix of communal social relations, had a number of consequences. It tended to blur the distinction between those who were mentally healthy and those who were mentally ill. From a very early stage psychiatric social workers began to question many of their basic assumptions. For example, psychiatric social workers found it increasingly difficult to locate the 'norms' against which the 'problem family' or the 'maladjusted' individual were to be measured. Writing in 1949, E.M. Goldberg admitted that psychiatric social workers were beginning to realize that the early family relationships, which they had been intensively studying, were highly complex. She went on to stress that cultural practices and norms could not be separated from

⁷⁰ John Bowlby, 'The Field of Future Research', p42.

⁷¹ John Bowlby, 'The Field of Future Research', p42.

human relationships.⁷² It followed from this, she argued, that psychiatric social workers needed to question what in fact they were asking their patients to adjust to. In the early 1950s Elizabeth Irvine admitted that 'problem families are easy to recognize and describe, but surprisingly hard to define'.⁷³ Similarly, Pauline Shapiro devoted an article in 1952 to fundamental uncertainty amongst tutors of childcare courses about what actually constituted a 'normal home life'.⁷⁴ In 1949 Sybil Clement Brown, the former tutor of the London School of Economics Mental Health Course, noted that the general concern of those working in child guidance to emphasize a preventive service risked selection of children only on the basis of problem behaviour defined by other institutions. 'We must', she argued, 'guard against a definition of problems only by those who stand to gain by their prevention'.⁷⁵ Another psychiatric social worker, speaking at a 1953 conference on mental health, warned of the danger of a psychiatric 'technical authoritarianism' whereby experts kept themselves in work by creating problems and 'anxiety' in the community.⁷⁶ Such a view implicitly incriminated mental health workers in the dynamics they sought to influence. At the same time it raised doubts about how psychological experts could, in fact, delineate which relations and norms constituted the history of emotional development they claimed to have discovered.

⁷² Goldberg, E.M., Comment on F.E. Waldron, 'The Meaning of the Word "Social" in Psychiatric Social Work', *British Journal of Psychiatric Social Work* 3 (1949) 7-18 at, p20.

⁷³ Irvine, Elizabeth., 'Research into Problem Families: Theoretical Questions arising from Dr Blacker's Investigations', *British Journal of Psychiatric Social Work* 2 (1954) 24-33, p24.

⁷⁴ Shapiro, Pauline., 'The Search for a "Norm" in Home Life', *British Journal of Psychiatric Social Work* 2 (1952) 4-9.

⁷⁵ Clement Brown, Sybil., comments at a Conference on Mental Health, *Report of the Proceedings of a Conference on Mental Health Held at St Pancras Town Hall, London, NW1. 14th-15th November 1946* (London: NAMH, 1946) p100-101.

⁷⁶ Hamilton, M., speaking at, *The Practical Application of Research and Experiment to the Mental Health Field: Proceedings of a Conference held at Royal Victoria Halls, London, W.C.1 5th-6th February 1953*, p94.

This reflexive questioning is clearly associable with the contemporary criticisms of the mental deficiency system detailed in the previous chapter. Psychiatrists at the Fountain hospital, along with Jack Tizard and Neil O'Connor, and the NCCL, had all shown that diagnostic categories were unreliable indicators of mental and social capabilities (a conclusion also suggested by the Social After-Care Service' discovery of the number of people diagnosed psychotic able to live and work in the community); that the homogeonization of a group of people under the label mentally deficient as a 'social problem' could not be sustained; that grouping people into categorizations such as 'feeble-minded' could be crudely inaccurate; and that there was as wide a spectrum of behaviours and experiences amongst people diagnosed mentally deficient as amongst the rest of the population. Moreover, the role and effects of those in medical and administrative authority who had claimed to be straightforwardly applying the principles of 'stabilization' and training were criticized and placed into doubt. They were shown to create many of the behaviours and social problems that they claimed to isolate and treat. And indeed their response to such criticisms often appeared to be similar in its 'unreasoning stubbornness' and inability to listen to another view that had characterized their descriptions of mentally deficient people themselves. One might in fact paraphrase Bowlby and state that; 'It takes two to make a mentally deficient person.'

*The Hierarchy of Mind Disrupted: Detaching the Requirements of Emotional Health
From the Requirements of Full Citizenship.*

In this section I discuss how the childcare theorizing developed by mental hygienists during the war was finally extended to encompass children categorized as mentally deficient. (By 1959 this term had been replaced by the terms 'subnormal' or 'mentally handicapped'). This extension had the effect of further dislocating the discourse of emotionality from histories of individual and societal development that tied notions of mental health to full citizenship.

Ever since the war the discourse of emotionality (based on the analysis of emotional relations) had imbued theorizing on residential childcare for children, including those deemed maladjusted and Educationally Sub-Normal (ESN). But the principles of care, which were based upon it, were not applied to what were termed the 'lower grades' of mentally deficient children and adolescents. The reasons for this have been glossed over in accounts of changes in mentally deficient children's care.⁷⁷

Institutional care provided for these people continued to be heavily overcrowded, under funded and under staffed by poorly trained personnel. But this fact alone does not explain why the theorizing mental hygienists developed during wartime was not even directed to this area of care.

We have seen, however, that a major reason was that there was a theoretical occlusion regarding children diagnosed as mentally deficient. This was grounded in a specific history of societal and individual development that tended to exclude those whom it

⁷⁷ For example, Ann Shearer, *Handicapped Children in Residential Care: A Study of Policy Failure* (London: Bedford Square Press, 1980).

was considered were the product of arrested development. Their emotionality continued to be viewed as mostly instinctual and primitive. It required little receptivity. With their development arrested these people were mostly deemed lacking the capability to be raised to full and complete citizenship; the very goal that attention to the subtle stages of emotional development had grown around.

But, in work begun at the end of the 1950's, Jack Tizard brought children categorized as mentally deficient (subnormal) fully onto the discourse of emotionality.⁷⁸ The thesis of, what became known as the Brooklands study, was simple. It was that, 'severely retarded children are entitled to the same opportunities and quality of care that we give to normal children.'⁷⁹ Tizard took the principles of childcare recommended by the Curtis Committee (and promoted by the NAMH) for normal or 'maladjusted' children deprived of a home life and attempted to apply them to children categorized as imbecile. Mental hygienists and the Curtis Committee had considered these measures to be inappropriate for mentally deficient children.⁸⁰ Tizard, on the other hand, saw no reason why children deemed mentally deficient should not be considered to have similar 'intellectual, social and emotional needs'.

The project attempted to create a small 'family style' atmosphere. It provided for a group of children of mixed sex and age ranges between 4 and 10 years. (The children's measured mental ages were given as, half between 3 and 4 years, and a quarter less than 2 years). The concept of 'housemothers' was employed with children

⁷⁸ Jack Tizard, *Community Services for the Mentally Handicapped* (London: Oxford University Press, 1964).

⁷⁹ A.D.B. Clarke and B. Tizard, *Child Development and Social Policy: The Life and Work of Jack Tizard*, p4.

⁸⁰ See, *Report of the Care of Children Committee* [Curtis Committee] (London: HMSO, 1946) [1964] Cmd.6922, para508-509.

divided into 'family' groups. Close affectionate care was pursued and continuity of relations between particular staff and children attempted. Emphasis was placed on what were perceived to be the children's existing emotional needs, rather than the then prevailing attention on education and training.⁸¹ The traditional historical delineations that informed mental hygienists' contentions about the emotional lives of mentally deficient people had suggested that they were relatively primitive and simple. But, in contrast, Tizard maintained that severely retarded children's emotional problems were in some ways actually more complex.⁸² Tizard considered the children to be suffering from profound emotional maladjustment as well as mental handicap. He highlighted two areas that had been particularly emphasized by the NAMH in their evidence to the Curtis Committee. Some of the children's difficulties were attributed to the 'sudden and profound' change in their lives brought about by their move to Brooklands. The majority of staff at their new home were unknown to them, and at first changed as much as at hospital. Familiar routines disappeared and new experiences were thrust upon them. Echoing John Bowlby's attachment theory Tizard remarked that: 'The children were thus in the kind of situation that children face when they go unprepared to hospital.'⁸³ But, Tizard considered their institutional upbringing to be the more important factor, in the children's emotional maladjustment. Tizard reported that his study showed these children suffered strongly from emotional maladjustment due to institutional deprivation and lack of close and continuous affectionate relationships. As with the wartime critique he condemned large-scale institutional provision that was ordered for organizational efficiency and staff interests. This, he showed, was detrimental to child development and mental health. Discussing the initial problems of settling children in at Brooklands Tizard noted that:

⁸¹ Jack Tizard, *Community Services for the Mentally Handicapped*, p101.

⁸² Jack Tizard, *Community Services for the Mentally Handicapped*, p60 and 121.

⁸³ Jack Tizard, *Community Services for the Mentally Handicapped*, p97.

Not only were they severely subnormal intellectually, but they were institutional children, used to a constant routine and the uniformity of experience of ward life in a hospital. Their lives were, inevitably governed by ward practices, rather than by emotional links with particular adults with whom they identified themselves.⁸⁴

Tizard listed five characteristics amongst the children that expressed the effects of their upbringing:

...lack of speech; inability to play; extreme emotional lability coupled with apathy; grossly asocial and immature behaviour; and an extreme dependence upon adults with, on the other hand, hostility towards them.⁸⁵

Tizard reported that at Brooklands children's emotional maladjustment gradually became considerably lessened, their ability to play socially and constructively improved, and they developed close attachments to staff and other children. All became more independent in caring for themselves and their ability to use and understand language improved drastically.⁸⁶ These results were contrasted with the effects of institutional provision. All the children had been selected from the Fountain hospital where conditions were poor and typical of those in many institutions for mentally handicapped children at the time. At the Fountain children lived on wards of 60 beds with harassed nurses unable to provide individual attention amidst constant noise. Incontinence was a constant problem and the smell of faeces and urine was

⁸⁴ Jack Tizard, *Community Services for the Mentally Handicapped*, p96.

⁸⁵ Jack Tizard, *Community Services for the Mentally Handicapped*, p96.

⁸⁶ Jack Tizard, *Community Services for the Mentally Handicapped*, p130, 133-4.

often impossible to eradicate. Children were grouped together by sex, age and level of handicap. In such conditions, younger 'imbecile' and 'higher-grade' children were unable to learn speech or elements of social living. Tizard noted that the effects of emotional deprivation were clear amongst the children.

'Rocking and head-banging were commonly observed; they crowded around strangers, clutching and pawing them. The children were apathetic and given to tantrums. They rarely played.'⁸⁷

The impact of this study was that it established the importance of the discourse of emotionality regardless of measured intellectual capacity. Thus, the history of arrested mental development, associated with 'primitive', 'inferior', emotionality requiring containment and control, was in principle subverted. As we have seen, the discovery of a large bulk of children in Homes during the war considered to be 'backward', had been attributed by mental hygienists, to the unnatural emotional institutional life itself and to the failure of staff to recognize that such children required care and understanding based on their mental rather than their chronological age. These childcare theorists had, nevertheless, excluded mentally deficient children from their theorizing. Tizard, however, followed the logic of the emotional-relational problematic. A judgement of retarded mental capacity could no longer convincingly determine an alternative form of care based around a conceptualization of retarded emotionality. In so doing this study fractured mental hygiene's functional imperative; it cut the discourse of emotionality free from its linkage to developmental history and the need for 'efficient' citizenship.

⁸⁷ Jack Tizard, *Community Services for the Mentally Handicapped*, p79.

The influence of this study was strong.⁸⁸ But psychiatrists and psychologists working for mental hygiene did not immediately accept the full implications. The imperative of mental hygiene- to weld together the individual and society in a functionalist developmental harmony under the principle of mental health- remained strong in much of the literature. This was reinforced by a growth in the application of developmental psychology to mental deficiency. Tizard had himself played an important role in this. But, in the hands of many psychologists this entailed the subordination of emotional experience to grading people's potential for development and social adaptation to the community. NAMH booklets and training guides maintained that mentally subnormal people, like other human beings, were 'social beings dependent on social interrelationship with other people'.⁸⁹ But this was largely reduced to an emphasis on these people's inherently deficient emotional maturity and the consequent need for training and socialization *in order* that adequate relational abilities might be crafted.⁹⁰ Indeed, in 1963 A.D.B. Clarke criticized what he called 'the sentimental approach' in adult training centers, which he claimed, suggested that these people should be cushioned from life and not pressed to do useful work.⁹¹

H.C. Gunzburg, a leading psychologist associated with NAMH through the 1960's, maintained that much had changed in mental deficiency work since the early post-war years. He contended that, due to the great advances in developmental psychology

⁸⁸ Kathleen Jones, *Opening the Door: A Study of New Policies for the Mentally Handicapped* (London: Routledge & Kegan Paul, 1975), p4-5.

⁸⁹ H.C. Gunzburg, *Senior Training Centres: An Outline of the Principles and Practices of Social Education and Training for Older Mentally Subnormal People* (London: NAMH, 1963), quote at p7; A.D.B. Clarke, *Recent Advances in the Study of Subnormality* (London: NAMH, 1969), p24.

⁹⁰ H.C. Gunzburg, *Junior Training Centres: An Outline of the Principles and Practices of Social Education and Training of the Mentally Subnormal Child*. (London: NAMH, 1963) [reprinted 1966].

⁹¹ Cited in *Mental Health* 22 No.5 December 1963, p189.

mentally subnormal people were no longer herded into colonies 'out of sight out of mind'⁹². But the training in socialization he advocated might well be considered simply a subtler, and more socially acceptable, version of 'out of sight out of mind'. In a NAMH booklet published in 1963, in which he outlined the principles of Junior Training Centres, Gunzburg maintained that:

The subnormal is conspicuous by the way he is 'different' from others – he draws attention and reacts, often negatively, to this attention. Learning those skills and that behaviour which will make him inconspicuous, because he conforms thereby to the general standards, will in many ways ease his adjustment difficulties, and also make it easier for the community to tolerate and to accept him. ... The junior training centre has the task of initiating this type of social education, which will make it possible for many ... to lead an unadventurous, humble and modest existence in the community...⁹³

Why unadventurous? What indeed *is* an unadventurous existence? Why humble and modest? These objectives only really make sense when placed in the context of the traditional aims of mental hygiene; to pay attention to stages of emotional development for the sake of progressive socialization to full and responsible citizenship. Such a statement is, in effect, a reiteration of the hierarchies of mind promoted by mental hygienists between the wars. This rendition of developmental psychology is a psychology of deficiency. Socially constructed measurements of mental capacity place individuals in a hierarchy of minds, which is then transposed to a hierarchy of the social order. Already deemed deficient in such terms the best these

⁹² H.C. Gunzburg (ed) *Advances in the Care of the Mentally Handicapped* (London: British Society for the Study of the Mentally Handicapped, 1973). Introduction, p1.

⁹³ H.C. Gunzburg, *Junior Training Centres*, p15.

people might hope for would be to find a place relatively un-noticed at the bottom of the social hierarchy.

Ironically these imperatives were shown, by an anthropologist working at a U.S. department of psychiatry, to be the common experience forced upon patients released from mental deficiency colonies. He drew on Erving Goffman's description of the 'mortification' of the self in 'total institutions' in order to show how ex-'high-grade' patients from mental deficiency institutions attempted to cover themselves with a 'cloak of competence' in order to hide their stigma and lowered self-esteem. His work tried to show the painful experience of attempting to 'pass' in the community.⁹⁴ In their attempt to 'pass' in the social order all these people recognized a need to hide the histories that had been perpetrated on them. All denied and resented their categorization as mentally deficient or 'arrested' in development.⁹⁵ All went to extreme lengths to pass as normal fearing that failure would result in forcible return to hospital. They created 'new' pasts by collecting souvenirs of a 'normal' biography and displaying them in their homes. Most received little mail but all valued this as an expression of normality and many left real or fabricated letters around their homes. All were desperate not to stand out, and avoided contact with other ex-patients for fear of social contagion.

The Brookland's study, nevertheless, ultimately proved to have a strong influence, both on childcare, and the expressed policy of NAMH. Like the wartime developments on which it was based, the study represented a critique of prevailing standards and methods of institutional care. In this, it was associated with the

⁹⁴ Robert B. Edgerton, *The Cloak of Competence: Stigma in the Lives of the Mentally Retarded* (London: Cambridge University Press, 1967).

⁹⁵ Robert B. Edgerton, *The Cloak of Competence*, chapter four and five.

growing view that long-term institutional care could, in fact, promote mental disorders. In the following section I discuss how this notion continued to be closely associated with the mental hygiene problematic.

Healthy Emotional Relationships Versus Institutionalization.

In 1955 the deputy Superintendent of Claybury hospital published an influential article with 'institutionalization' as its title.⁹⁶ In this he noted that phrases such as 'becoming institutionalized' or 'well institutionalized' were commonly found in clinical notes. To be 'well institutionalized' implied being well behaved, giving no trouble, and ceasing to question one's position as a patient. Martin maintained that this process was in fact detrimental to the therapeutic aims of the hospital. Echoing, T.P. Rees' criticism of the traditional medical model, he pointed out that the process was not one that could be easily attributed to the end-result of an internal mental disease since it was so common across diagnostic classes.⁹⁷

These views were mirrored and developed by others. D.H. Clark the Superintendent of Fulbourn mental hospital near Cambridge was an influential advocate of therapeutic community style approaches to care and treatment. During the 1950's and 60's he developed a close association with NAMH.⁹⁸ Clark criticized the medical model, which posited a disease process that happened inside the patient.⁹⁹ The psychiatrist Russell Barton added his own spin on these views. Barton was a

⁹⁶ Denis V. Martin, 'Institutionalization', *Lancet* 2 1955 1188-90.

⁹⁷ Denis V. Martin, 'Institutionalization', p1188.

⁹⁸ He became Vice-Chairman of NAMH in 1966. See Annual Report 1966-67, p22.

⁹⁹ David H. Clark, *Social Therapy in Psychiatry* (Harmondsworth: Penguin, 1974), p65.

prominent member of the NAMH through the 1960's, serving on its Executive Committee and Council of Management.¹⁰⁰ In 1959 he published an influential short work entitled *Institutional Neurosis*.¹⁰¹ This maintained that long term mental patients acquired a further mental disorder, caused by the institution itself, in addition to their presenting one on admission. But he contended that this condition could no longer simply be understood as the end result of the illness that had brought the patient into hospital. And, significantly, he maintained that appropriately trained staff, educated of its aetiology, could through their actions 'cease to produce it'.¹⁰²

These conceptualizations of the therapeutic and anti-therapeutic nature of the mental hospital were not without their tensions in respect of the programme for mental hygiene. For example, Russell Barton's monograph was praised in a review by one mental hygienist and yet the processes of institutionalization Barton had detailed were reduced to 'abuses and shortcomings' occasionally ignored by staff. The remedy, this reviewer contended, was simply to reverse the gross under-staffing in hospitals.¹⁰³ But, such views notwithstanding, all of these conceptualizations of institutionalization and therapeutic relations repudiated the traditional image of the mental patient as an 'isolated individual, inside whom things are happening'. And, in so doing, they also introduced social contingency into the clinical course of illness. Different patterns of symptomatology and different patterns of experience varied in different social and relational environments. In addition they placed patients' experience at the centre of this relational milieu.

¹⁰⁰ NAMH, Annual Report 1961-2 through to 1969-70.

¹⁰¹ Russel Barton; *Institutional Neurosis* (2nd ed) (Bristol : John Wright & Sons Ltd, 1959).

¹⁰² Barton; *Institutional Neurosis*, p16

¹⁰³ R.F. Tredgold, review of Russell Barton, *Institutional Neurosis* (London: John Wright & Sons, 1959) in *Mental Health* 19 1 Spring 1960, p32-3.

Russell Barton's booklet on 'institutional neurosis' was published at the same time as another critique of institutional care that became extremely influential. The sociologist Irving Goffman produced a series of articles on mental hospitals at the end of the 1950's that were published as a book entitled *Asylums* in 1961.¹⁰⁴ Goffman's analysis was not another element of the altered problematic of mental hygiene. But in fact it had close associations with critiques of institutional care based upon it. Goffman contended that:

The society's official view is that inmates of mental hospitals are there primarily because they are suffering from mental illness. However, in the degree that the 'mentally ill' outside mental hospitals numerically approach or surpass those inside hospitals, one could say that mental patients distinctively suffer not from mental illness, but from contingencies.¹⁰⁵

With this argument he was merely performing a similar manouvre to that previously made by the NCCL and psychiatric and psychological professionals applying the problematic of emotional relations to mental deficiency services. Mental hygienists had traditionally employed estimated prevalence figures of people in the community deemed mentally deficient to justify the need for greater ascertainment and control. As we have seen, both the NCCL and Jack Tizard reversed this logic by arguing that this apparent presence in large numbers in the community showed that these people needed no such special measures.¹⁰⁶ In the process they implicitly contested the elision of individual and societal historical progress that underpinned mental

¹⁰⁴ Irving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday, 1961).

¹⁰⁵ Erving Goffman, *Asylums* (Harmondsworth: Penguin, 1991), p126.

¹⁰⁶ See chapter four.

hygienists' claims as mediators of mental and societal 'health'. For his part, Goffman introduced alternative, and more intimate histories. His description of the 'career' of the mental patient presented a process of contingencies that lead from 'pre-patient' to 'in-patient'. Only in retrospective reconstruction, he claimed, could these contingencies become case histories of a progressive mental illness.¹⁰⁷ This was not a description of histories invoked so as to provide a glue to bind together a moral order. Goffman's work clearly championed the patient's perspective and was openly critical of the psychiatric system. Critics of the rights strategy adopted by NAMH in the early 1970's have described him as an 'anti-psychiatrist', and placed this nebulous 'movement' as an important influence on rights thinking in mental health. The implication is that, both 'anti-psychiatry' and the rights approach were categorically opposed to the psychiatric system.

But, in fact, a number of influential figures associated with mental hygiene were clearly receptive to Goffman's work. His approach had much in common with those developing the logic of the emotional-relational frame of reference. Russell Barton employed Goffman's concept of 'total institutions' and their effects in the application of his concept of 'institutional neurosis' to hospitals for people diagnosed mentally handicapped.¹⁰⁸ David Clark was strongly influenced by Goffman's description of the 'moral career' of the mental patient.¹⁰⁹ Others responded favourably to his description of the social construction of stigma in society.¹¹⁰

¹⁰⁷ Erving Goffman, *Asylums* (Harmondsworth: Penguin, 1991), p134-5.

¹⁰⁸ Russell Barton, 'The Institutional Mind and the Subnormal Mind' in, H.C. Gunzburg (ed) *Advances in the Care of the Mentally Handicapped* (London: British Society for the Study of the Mentally Handicapped, 1973) 13-20.

¹⁰⁹ David H. Clark, *Social Therapy in Psychiatry* (Harmondsworth: Penguin, 1974).

¹¹⁰ For instance, a psychiatrist closely associated with the NAMH favourably reviewed Goffman's later book *Stigma* in 1964, see Douglas Bennett, 'Social Attitudes and Mental Disorder', *Mental Health* 23 6 December 1964., p241-2.

Jack Tizard's Brooklands study spurred further research and theorizing in mental deficiency that also made use of Goffman's concept of 'total institutions' as a conceptual framework. In 1963 Tizard set up the Child Welfare Project with Norma Raynes and Roy King. This produced a comparative study of institutions, their organization, and effect on childcare.¹¹¹ Building on the Brooklands work, these studies sought to differentiate between 'institutionally oriented' care – as encompassed by Goffman's total institution ideal type – and 'inmate oriented' care, generally encompassed by the 'family' model of care promoted by mental hygienists for 'normal' children during the war and by Jack Tizard at Brooklands.¹¹² They found justification for this manouvre in Goffman's work itself. He had suggested that total institutions were incompatible with the 'family', which he called a 'crucial element of our society'.¹¹³

Closely associated with this work was the Wessex project, which Tizard also helped to set up. This scheme carried out an epidemiological study of local requirements and then set up a series of small community residential homes for children and adults categorized as severely mentally handicapped.¹¹⁴ Its director, the psychiatrist Albert Kushlick, employed the same differentiation between institutional and inmate oriented care.

¹¹¹ Roy D. King, Norma V. Raynes and Jack Tizard, *Patterns of Residential Care: Sociological Studies in Institutions for Handicapped Children* (London: Routledge and Kegan Paul, 1971).

¹¹² Norma V. Raynes and Roy D. King, 'Residential Care for the Mentally Retarded', in *First International Congress for the Scientific Study of Mental Deficiency* (Montpellier: Surrey, 1967) Reprinted in, David M. Boswell and Janet M. Wingrove, *The Handicapped Person in the Community* (London: Tavistock and OUP, 1974) 299-306, p299.

¹¹³ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Harmondsworth; Penguin, 1961) [1991], p21-22; Roy D. King, Norma V. Raynes and Jack Tizard, *Patterns of Residential Care*, p115-116.

¹¹⁴ Albert Kushlick, 'The Need for Residential Care', in Victoria Shennan (ed) *Subnormality in the 70's: Action for the Retarded* (London: NCMHC and WFMH, 1972) 13-26. A.D.B. Clarke and B. Tizard, *Child Development and Social Policy: The Life and Work of Jack Tizard*, p4.

These projects considered institutionally oriented care to be characterized by; rigidity of routine; block treatment; depersonalization; and social distance. But this was not simply an echo of Goffman's description of total institutions. These are clear criteria highlighted by mental hygienists directing their emotional-relational problematic to residential child care, and they echo the therapeutic community approaches trying to combat institutionalization.

Regarding 'subnormality', by the late 1960's NAMH was publicly arguing that merely increasing financial or staff resources would not solve the endemic problems in mental handicap hospitals. The work of Tizard and Kushlick was cited as showing that alternatives to traditional hospital care were both necessary and possible.¹¹⁵ NAMH was able to assert that there had been an 'impressive expansion in knowledge of the needs of mentally handicapped children ...'.¹¹⁶ But it continued:

The concept of treatment for the mentally handicapped in hospitals embodied in the Mental Health Act has never been sufficiently discussed. What is this treatment? Who should undertake it? To what extent are these hospitals 'homes', and if homes, how 'homelike' are they?¹¹⁷

NAMH asked, in this context of promoting 'growth and the enjoyment of life'; what were the 'essential skills' of the nurse? Were the skills of the psychologist sufficiently directed to this goal? The report went on: 'Have the findings about maternal deprivation, so familiar to the child-care world, been applied to the grossly

¹¹⁵ Editorial, *Mental Health* Summer 1969, p16-17.

¹¹⁶ NAMH, Annual Report 1969-70, p4.

¹¹⁷ NAMH, Annual Report 1969-70, p4.

handicapped child in hospital?' ¹¹⁸ NAMH, aware of its involvement in the development of this childcare philosophy, was apparently unaware of its complicity in the construction of its restricted applicability. But, this occlusion of memory notwithstanding, NAMH now maintained that:

Our main concern is with the individual and his mental health, whatever his innate intellectual capacity. That the ability of the mentally handicapped to enjoy life should not be impaired by a lack of human warmth, appropriate assessment and every opportunity for self-fulfilment.¹¹⁹

Emotional Relations, Institutionalization and Power Relations: The Mental Hygiene Problematic Lays the Ground For the later Rights Strategy

Both the concept of 'institutionalization' and that of the hospital as a therapeutic community became commonplace by the 1960's. As we have seen, both of them were associated with mental hygiene. In fact they represent two sides of the emotional relational problematic. Institutionalization, in effect, came to represent a paradigm for the type of inter-personal relationships that were conducive of mental ill health. Meanwhile the general notion of a therapeutic community became a symbol for its opposite.

Nikolas Rose has cast the concept of institutionalization in terms of a perception that large hospitals produced conditions which confounded the psychiatric goal of

¹¹⁸ NAMH, Annual Report 1969-70, p4.

¹¹⁹ NAMH, Annual Report 1969-70, p5.

reactivating, private monads. He has maintained that responses to this were part of a broader 'reframing and reorganization' of the psychiatric system that, in fact, extended psychiatry's power in the construction of the isolated, private, individuals it took to be 'universal attributes of personhood.'¹²⁰ This is misleading. In fact one of the principle concerns about institutionalization was that its effects were considered emotionally and psychologically isolating. The commonly used term 'de-personalization' was primarily a reference to what was perceived as an arrestment or reversal of the sociability considered essential to emotional health. As we have seen this is all of a piece with the emotional-relational problematic deployed from wartime. The functionalist agenda pursued by mental hygienists from this time cast healthy and nurturing inter-personal relationships as the basis of the integration of individuals and society in a 'healthy' equilibrium. Healthy emotional development was linked to full and responsible citizenship through concentric stages of widening sociability.

What is important about the growing influence of the term institutionalization is not that it re-asserted a purported ongoing psychiatric aim of attempting to reconstruct self-contained private individuals. Instead it is that, along with the concept of the therapeutic community, the term's association with a conceptualization of mental health in terms of the quality of relationships challenged hierarchy and authority, and, in consequence, therapeutic approaches perceived to be incriminated with them. This represented a fatal undermining of the moral therapy problematic that the mental hygiene movement had been built around. And, as we will see, it in fact, informed the rights strategy adopted by NAMH when it re-labelled itself MIND in the early 1970's.

¹²⁰ See Nikolas Rose, 'The Discipline of Mental Health' in, Peter Miller and Nikolas Rose (eds) *The Power of Psychiatry* (Cambridge: Polity Press, 1986) 43-84, and Nikolas Rose, 'Law, Rights and Psychiatry', in the same volume, 177-213. Terms in quotation marks taken from the latter article, p204 and p201 respectively.

We have seen that Russell Barton labeled the mental debilitation that he understood to be a common consequence of hospital care as 'institutional neurosis'. In a later article, discussing the same issues, Barton described the set of relations that caused this as the 'institutional mind'.¹²¹ This is a useful metaphor because it helps to illuminate the way in which attending to the quality of emotional relationships, as a principle of mental health and disorder, subverted the moral therapy problematic. Essential to moral therapists' original framing of mental disorder and its treatment was the application of one particular kind of mind over another. The former mind was pre-conceived to be all that the other was not. Rational, reasonable and objective, it engaged in a 'battle of wits' with the latter mind. Through the relentless application of a moral 'eye' this reasonable mind sought to resurrect reason and responsibility in the other. It thus adopted a position of perpetual judgement. A right to isolate and define irrational 'character' that constituted a problem to self and others, and a right to influence the internalization of norms. I have described moral therapy as a one-way reason that can brook no reply other than in terms of the definition that it supplies. From this perspective the patient is either recalcitrant or cured but never able to legitimately contest either their definition or the therapeutic approach. It was this problematic that mental hygiene originally adopted. But which - through a series of shifts of reference that ultimately came to a perception of emotionality and mental disorder in terms of interacting relationships - it finally undermined.

In Barton's characterization of the 'institutional mind' we have an image of the original moral therapy problematic. He cast this 'mind' as an 'authority system' with three

¹²¹ Russell Barton, 'The Institutional Mind and the Subnormal Mind'.

characteristics. It was a hierarchical order of staff and patients, with the latter at the bottom. It was an authority that cast an ever present and intimate surveillance which judged and attempted to control matters such as 'dress, deportment, social intercourse, manners...'. Lastly, this judgement was so pervasive that misdemeanors in one area of life became a definition carried across to other spheres.¹²² In effect we have here a moral therapy reduced to three elements.

Hierarchies in Doubt: The Relations of Therapy.

We have seen that the wartime experiments all considered 'healthy' emotional relationships to be both the means and the end of therapy. But many post-war mental hygienists, as we have also seen, tended to reduce this to a conception of themselves as manipulators who could create the kinds of relationships in which emotional health would develop. In effect this continued the power relation embodied in the moral therapy problematic. With this therapists could retain themselves and their professed expertise outside the frame of reference while the question to be solved was reduced to how to make relationships manifest an already preconceived notion of mental health and adjustment.

However, the idea that therapy should embody the healthy emotional relationships seen as its goal continued to have an influence on many of the approaches discussed in this chapter. As T.A. Ratcliffe, for instance aptly put it regarding psychiatric casework, 'not only is treatment intended to aid the patient to build up future

¹²² Russell Barton, 'The Institutional Mind and the Subnormal Mind', p14.

relationships, but the building up of a relationship is itself the treatment process.¹²³

The historian Rhodri Hayward has recently argued that, in dealing with the psychological complaints of their patients, doctors in the 1930's engaged themselves in a moral project of perfecting their own characters in order to deploy them as a therapeutic agent.¹²⁴ If we accept this view, then the shift to confronting the complex relational aspects of emotional health should be construed as extending this to attempting to make the relational environment as a whole embody mentally healthy and health producing characteristics. The relational milieu was to be the therapeutic agent by sustaining the kind of relationships that represented mental health.

But what were healthy and health providing relationships? The wartime experiments had all outlined what they were not. They were not the product of rigid hierarchy or authority. They were not the product of insensitive and unreflective staff attitudes. They were not the product of relationships in which things were done to, and for, passive or unwilling patients. If overt authority, hierarchy, and the implied emotional insensitivity they embodied, were detrimental, then therapy should embody the opposite. At Northfield Tom Main had referred to the environment in which emotionally healthy relationships were sustained as 'spontaneously structured communities'. Post-war, in significant areas of mental hygiene activity, similar ideals were expressed. On these views, therapy became in essence, an attempt to remove the obstacles to spontaneous emotional relationships.¹²⁵ One element of this was an

¹²³ T.A. Ratcliffe and E.V. Jones, 'Intensive Casework in a Community Setting', *Case Conference* 2 No.10 March, 1956 17-23, p22.

¹²⁴ Rhodri Hayward, Work in Progress Paper, Wellcome Trust Centre for the History of Medicine, 10th March, 2004.

¹²⁵ E.E. Irvine, 'Two Approaches to Adjustment Problems Among Children in Institutions', *British Journal of Psychiatric Social Work* 2 No.1 1951 6-12, p11.

attempt to remove what was seen as the hindering effect of control and authority associated with therapy.

Freedom and Choice.

The wartime experiments had reconfigured the notion of voluntary treatment. With this, freedom and choice became highlighted as constituents of a therapeutic relationship. These principles remained important at many sites of mental hygiene intervention. In psychiatric community casework, attempts at open communication and relationships were increasingly the hallmark of therapy. The psychoanalytic imperative of interpreting the transference, and the 'needs' of both the patient and the community, began to be subsumed by the concurrent injunction to be open and sensitive to the reciprocal nature of two-way emotional interaction. In 1956 the psychoanalytically trained psychiatric social worker, Elizabeth Irvine, remarked that she increasingly believed interpretation to be less important than the 'counter transference'; the effect of the social workers feelings on the client. She went on to contend that too much emphasis had been placed on interpretation and not enough on the 'value of the type of question which leads the client to finding his own interpretation'.¹²⁶ It had at first been argued that 'counter-transference' could be eliminated (or diminished to an unimportant factor) by a psychiatric social worker's training and personal therapy. But workers in social care began to accept that even 'in the most "passive" setting of the strict psychoanalytical interview, there [was] a "feed-back" from therapist to client'.¹²⁷ Increasingly it was acknowledged that patients were

¹²⁶ E.E. Irvine, 'Transference and Reality in the Casework Relationship', *British Journal of Psychiatric Social Work* 3 No.4 1956 15-24, p21-22. (Quote at p22).

¹²⁷ T.A. Ratcliffe, 'Relationship Therapy and Casework', *British Journal of Psychiatric Social Work* 5 No. 1 (1959) 4-9. p8.

very aware of the emotional feelings and attitudes of therapists and that they often responded acutely to them. 'Whether we like it or not', T.A. Ratcliffe pointed out, 'one's clients, in any interview, are assessing one as a person, as well as in the transference setting'.¹²⁸ We have seen that NAMH believed that clients should, whenever possible be able to choose their own social worker. This was considered a therapeutic issue. Post-war, Ratcliffe and his colleague E.V. Jones similarly spoke of some clients' psychological need to determine the timing and space between therapeutic sessions.¹²⁹

Similar principles imbued residential care. NAMH's hostel, Reynolds House, embodied the conviction that overt authority might enforce apparent acquiescence but was, in fact, more likely to damage the emotional interaction on which healthy mental adjustment was considered to rest. Children were only accepted after a preliminary visit and if they themselves wanted to come.¹³⁰ This emphasis on the need for voluntary choice regarding residential care for maladjusted children had been emphasized by the NAMH from the early 1950's.¹³¹ Similarly, just as at the wartime therapeutic communities, social order was deemed to depend on good relationships rather than overt authority. Wills emphasized that, 'to forbid anything, to give orders, was quite contrary to the ethos of the establishment'.¹³² He claimed that the house rule of respect for each other's liberty and convenience was applied with equal vigour to residents and staff. It was reinforced that each had an equal right to complaint on this

¹²⁸ T.A. Ratcliffe, 'Relationship Therapy and Casework', *British Journal of Psychiatric Social Work* 5 No. 1 (1959) 4-9. p8 and p9.

¹²⁹ T.A. Ratcliffe and E.V. Jones, 'Intensive Casework in a Community Setting', p20.

¹³⁰ Wills, David., *Reynolds House*, p20-21.

¹³¹ NAMH, *Committee on Maladjusted Children: Memorandum Submitted by the NAMH* 23rd June, 1952, p2.

¹³² Wills, David., *Reynolds House*, p64.

issue.¹³³ In common with his earlier practices developed in residential childcare, Wills also employed a form of self-government. This was also an element in the treatment of maladjusted children promoted by the NAMH.¹³⁴ Attempts at self-government were similarly made at hospitals developing the therapeutic community approach. Indeed D.H. Clark criticized the therapeutic community model advocated by T.P. Rees and the World Health Organization, in the 1950's, because it failed to institute this properly and thus left the emphasis 'still on treatment flowing from the doctor downward...'.¹³⁵ D.V. Martin, similarly placed great emphasis on developing methods of self-government and using this to flatten hierarchies. A 1964 review, in NAMH's journal *Mental Health*, praised his emphasis on the need to dismantle the traditional authoritarian structure of mental hospitals, and his associated promotion of free communication between staff, and between staff and patients.¹³⁶

On these views, direct attempts to 'adjust' people or manipulate relationships became viewed more as a violation of the self than a rehabilitation. In 1965, a lecturer at the National Institute for Social Work Training, was warning against the institutionalization of techniques, methods, and organization, leaving the needs of people ignored or 'forced into some preconceived mould'.¹³⁷ Summing up the conference at which he spoke, was the psychiatrist Martin James. He was closely associated with NAMH, serving on its consultant medical panel throughout the 1950's

¹³³ Wills, David., *Reynolds House*, p58.

¹³⁴ NAMH, *Committee on Maladjusted Children*, p11.

¹³⁵ D.H. Clark, 'The Therapeutic Community – Concept, Practice and Future', *British Journal of Psychiatry* 111 1965 947-954, p949.

¹³⁶ Emanuel Lewis, review of D.V. Martin, *Adventure in Psychiatry: Social Change in a Mental Hospital* in, *Mental Health* 23 No.1 February 1964, p26.

¹³⁷ Jones, David., 'Child Guidance and the Social Services: An Outsider's View', *Child Guidance: Function and Social Role: Report of the 21st Child Guidance Inter-Clinic Conference, 1965* (London: NAMH, 1965) 39-50. p43.

and 60's.¹³⁸ James announced that what he feared was the multiplication of experts. For him, psychiatric training, in particular portrayed people as 'machines' rather than people, desensitized doctors to emotionality, and engendered an authoritarian, paternalistic attitude.¹³⁹ It was within such a framework that in 1961 one psychiatric social worker referring to mental hospitals remarked that:

One of the purposes a caseworker can fulfil is in helping generally to humanize the hospital ...atmosphere by giving due recognition to the existence of *feelings* (as distinct from rules, duties, expediencies, etc.).¹⁴⁰

Another contended in the late 1960's that, psychiatrists' training had not helped them to 'deepen their humanity or their understanding of people in the community'. 'The question is', she wrote, 'how far the training of psychiatrists is moving to include content concerned with the meaning of life and feelings and relationships in society....'¹⁴¹

¹³⁸ See NAMH, Annual Reports.

¹³⁹ Martin James, 'Summing Up', *Child Guidance: Function and Social Role: Report of the 21st Child Guidance Inter-Clinic Conference, 1965* (London: NAMH, 1965) 39-50. p51-2.

¹⁴⁰ J. Woodward, 'Research and After', *British Journal of Psychiatric social Work* 6 No.2 68-73, cited in Barbara Butler, 'The Changing Role of the Social Worker' in, John D. Sutherland (ed), *Towards Community Mental Health* (London: Tavistock, 1971) 77-95, p90.

¹⁴¹ Butler, Barbara., 'The Changing Role of the Social Worker' in, John. D. Sutherland (ed) *Towards Community Mental Health* (London: Tavistock Publications, 1971) 77-95 p84.

The Power to Define Loosened.

A further significant element of prioritizing the fluctuating dynamics of emotional relationships was that it weakened the power of rigid diagnostic categories. As we have seen, delinquency was one area where this began to take place. But, in fact, it occurred across the sites of mental hygiene. Diagnosis became provisional and uncertain. Some, such as the psychiatrist Jack Kahn, made this a point of theoretical discussion. In 1963 he emphasized that diagnostic concepts and pathogenicity were of a relative nature.¹⁴² Others simply placed less attention on diagnosis. At Reynolds House, for example, Wills considered that clinical descriptions were, 'meaningless for practical purposes.'¹⁴³ Still others, through their application of the emotional-relational frame of reference, illuminated the anti-therapeutic impact of apparently fixed definitions of innate states. We have seen that the SACS worked with people previously considered 'chronic' and 'hopeless' cases. The post-war developments of psychiatric community casework continued this. T.A. Ratcliffe and his colleague E.V. Jones reported in 1956 that this type of therapeutic approach must resist dealing with people as 'types'.¹⁴⁴

Other theorizations in child guidance furthered the undermining of fixed diagnosis and classification. John Bowlby, for example, began his 1949 article, on group tensions in the family, with the comment that child guidance workers had come to recognize 'more and more clearly that the overt problem which is brought to the Clinic in the person of the child is not the real problem; the problem which as a rule we need

¹⁴² J.H. Kahn, 'A Wider Concept of Deprivation', *Clinical Problems in Children of Primary School Age: The Proceedings of the 19th Child Guidance Inter-Clinic Conference* (London: NAMH, 1963) 5-16, p7-8.

¹⁴³ Wills, David., *Reynolds House*, p36.

¹⁴⁴ T.A. Ratcliffe and E.V. Jones, 'Intensive Casework in a Community Setting', p18.

to solve is the tension between all the different members of the family.¹⁴⁵ Child guiders began to talk increasingly of illness having been 'projected' onto children.¹⁴⁶ Dugmore Hunter, Consultant psychiatrist at the Tavistock Clinic, asked, in 1955, 'Is the child with his presenting symptoms, really the most ill member of the family, or has he been forced into illness by a mother and father who for some reason must avoid awareness of disturbance in themselves and so provoke illness in the child [?]'¹⁴⁷ These ideas made it even into the normally conservative and anodyne promotional leaflets on the mental health services published periodically by NAMH. A leaflet written in the 1950's by the psychiatrist Jack Kahn, for instance, described the presenting problem of the child sent to the clinic for treatment as a maladjustment funneled into him or her by the group tensions of the family.¹⁴⁸ A later 1960's booklet on careers in mental health referred to a child guidance clinic as seeing 'not only "the one who is called the patient" ... but the whole family ...'.¹⁴⁹ By the 1960s notions of a mentally disordered person as 'scapegoat' or 'symptom bearer' of a confused, and disguised matrix of family relationships were commonplace amongst professionals working in community care and child guidance.¹⁵⁰

¹⁴⁵ John Bowlby, 'The Study and Reduction of Group Tensions in the Family', *Human Relations* 2 No.2 1949 123-128, p123.

¹⁴⁶ Rosalie Lucas, comments, NAMH, *Tenth Child Guidance Inter-Clinic Conference: Report on Conference and Some Selected Clinic Surveys* (NAMH: London, 1953) 28-30, p29.

¹⁴⁷ Hunter, Dugmore., 'An Approach To Psychotherapeutic Work With Children and Parents', *11th Inter-Clinic Conference For Staffs of Child Guidance Clinics: 'The Family Approach to Child Guidance- Therapeutic Techniques'*, (London:NAMH,1955)11-26, p12.

¹⁴⁸ Jack Kahn, *Child Guidance* (NAMH leaflet c1957), p3.

¹⁴⁹ Paul Vaughan, *Work to be Done: Careers in Mental Health* (London: NAMH, 1966) [2nd edition, 1967], p7.

¹⁵⁰ The reports of the Inter-Clinic Child Guidance Conferences show this clearly. See for example, *Child Guidance From Within: Reactions to New Pressures. Papers Given at the 23rd Child Guidance Inter-Clinic Conference 1967*. (London: NAMH,1967); *Mental Illness in the Family: It's Effect on the Child: Proceedings of the Twenty-Second Child Guidance Inter-Clinic Conference, 1966*. (London: NAMH,1966).

Questioning Power Relations

A term that was associated with the notion of the 'scapegoat' was 'collusion'. How were the members of the family colluding in channeling maladjusted relations in the family into an embodied maladjustment in a particular child? Was the child guidance team being drawn into colluding with them in this manouvre? More radically self-questioning contentions also surfaced. In 1965, a child psychiatrist at the Tavistock Clinic claimed that child guidance was colluding with the community in labeling more and more children 'ill' or 'maladjusted'.¹⁵¹ But similar issues had been raised years earlier. In 1949 the psychiatric social worker, E.M.Goldberg, had emphasized that the very creation of the discipline of psychiatric social work had implied a redefinition of mental disorder as 'social maladjustment'. She had gone on to remark:

Do we always remember that the deviants of to-day may be the 'normal' of tomorrow... . Do we ever stop to question the nature of our cultural norms that compel us to label an ever increasing number of people as neurotic or abnormal. Do we in fact make enough use of the accumulating knowledge which throws light on these questions.¹⁵²

In regard of child guidance, this notion of professional collusion was, on the whole, limited to an unwitting involvement in family emotional relations that funneled maladjustment or mental disorder into one person. But the same conceptual understanding of the dynamics of emotional relationships produced a more radical

¹⁵¹ H.M. Holden, 'The Ethic of Child Guidance', *Child Guidance: Function and social Role. Report of the 21st Child Guidance Inter-Clinic Conference, 1965* (London: NAMH, 1965) 12-25.

¹⁵² Goldberg, E.M., Comment on F.E.Waldron, 'The Meaning of the Word "Social" in Psychiatric Social Work', *British Journal of Psychiatric Social Work* 3 (1949) p20.

self-questioning at some therapeutic communities. In their study of staff and patient interactions at a mental hospital, Stanton and Schwartz suggested that staff anxieties, hostilities and collusions were participant in patients' behaviour and symptoms.¹⁵³ Influenced by these views, D.H. Clark traced out staff interactions that produced 'illness' behaviour in patients.¹⁵⁴ Similarly, D.V. Martin maintained that staff anxieties or disputes were found, time and again, to be canalized into disturbance in patients.¹⁵⁵ Both he and Clark considered the system of hierarchy and authority to be productive of this.

Martin maintained that staff and doctors both suffered from, and contributed to, the organizational pattern of life that caused institutionalization. Thus nurses often resorted to transferring patients to refractory wards as a means to deal with difficult behaviour. They would then rationalize this action rather than review possible relationship or organizational causes. Both Clark and Martin emphasized that staff in mental hospitals could easily avoid confronting unacknowledged or unconscious motives for their decisions. Nurses lacked training in the understanding of human relations and, partly as a result, could fall back on authority and the enforced submission of the patient. Similarly, doctors could 'hide behind' their traditional professional status, remaining distant from both nurses and patients. Those who found time and paid 'at least lip service to the importance of individual psychotherapy' nevertheless often allied themselves with an authoritarian hierarchy rather than engage fully in a relationship with the patient.¹⁵⁶ Highlighted was the power of professional hierarchies and training weighing against the creation of free criticism

¹⁵³ A.H. Stanton and M. Schwartz, *The Mental Hospital* (London: Tavistock, 1954).

¹⁵⁴ David Clark, *The Story of a Mental Hospital*, p57-9.

¹⁵⁵ D.V. Martin, 'Problems in Developing a Community Approach to Mental Hospital Treatments', *British Journal of Psychiatric Social Work* 5 2 (1959) 56-63., p59-60.

¹⁵⁶ Denis V. Martin, 'Institutionalization', p1190.

and opinion.¹⁵⁷ The development of community meetings and promotion of 'free communication' represented attempts to dismantle hierarchies and provide therapeutic relationships for both staff and patients. As the superintendent of nursing at the Bethlem and Maudsley hospitals told a 1964 NAMH conference, at a therapeutic community, therapy should not only be for the patients but also for the staff.¹⁵⁸

Similarly, both Martin and Clark argued that much violent and disturbing behaviour amongst patients that was attributed to the nature of their illness, was often produced by the repressive control engendered by the hospital hierarchy. Associated factors were revealed by Isabel Menzies, of the Tavistock Institute for Human Relations, whose influential work described how professional hierarchies at general hospitals created stress in staff and promoted the 'depersonalization' of both staff and patients.¹⁵⁹

At the sites where these measures took place, the patient gained a right to speak back. Their response no longer lay outside the therapeutic frame of reference since open communication had been deemed a central element of therapy. What was revealed was a power relation. David Clark later reflected on this as it was expressed at Winston house. This was a 'half-way' hostel linked to Fulbourn hospital and developed with the support of the Cambridgeshire Mental Welfare Association and NAMH.¹⁶⁰ Direct experience at the home made him begin to understand more clearly,

¹⁵⁷ Denis V. Martin, 'Institutionalization', p1189-1190; D.V. Martin, 'Problems in Developing a Community Approach to Mental Hospital Treatments', *British Journal of Psychiatric Social Work* 5 No.2 1959 56-63, p59.

¹⁵⁸ Miss E. Skellern, speaking at the 1964 NAMH Annual Conference, cited in, *Mental Health* 23 No.2 April 1964, p49.

¹⁵⁹ Isabel E.P., Menzies, 'A Case Study in the Functioning of Social Systems as a Defence Against Anxiety', *Human Relations* 13 1960 95-120.

¹⁶⁰ Clark, D.H., *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996) p128.

he believed, how the power of the psychiatrist in the hospital permeated the social relations within it. Through his work at the Home it was reinforced to him that most patients were very well aware and wary of the doctors power, for example, to order electro-convulsive therapy (ECT), confinement, seclusion or to deny discharge. Clark began to accept more fully that the psychiatrist's role in any therapeutic relationship could never be neutral; nor could it simply and always be therapeutic.

Gradually I learned...more subtle lessons and began to respect patients' judgement of their own needs. Some of them felt they had no need to see a psychiatrist again and I learned to accept that. Others were guardedly polite; their referring psychiatrist had spoken enthusiastically about how their psychoses had been cured and their state stabilised on Largactil; gradually, as they came to trust me, they revealed that for many months they had been putting the pills down the lavatory.¹⁶¹

Moral therapists had combined a policy of 'sensitivity with strength' with an understanding that patients could at times be sensitive to a gentleness of approach.¹⁶² This sensitivity on the part of the patient, was not, however considered to represent a source of knowledge and experience that could counter the knowledge and authority of the therapist. Under mental hygienists' new conceptual framework this distinction began to collapse. As we have seen, therapy began to take on a role of attempting to remove the barriers to 'healthy' emotional engagement. With such a view therapeutic knowledge itself could come into view as a potential obstruction itself.

¹⁶¹ Clark, D.H., *The Story of a Mental Hospital* (London: Process Press, 1996) p142.

¹⁶² Roy Porter, 'Shaping Psychiatric Knowledge: The Role of the Asylum', p261.

The knowledge given to us during our training was very useful, in so far as we could bring it to life. But we feel it could be an obstacle when it is not a growing part of ourselves. A common pitfall, for instance, is to let our knowledge come between us and spontaneous reactions towards other people, to reduce each varied and ever changing personality to a preconceived pattern, to mistake a useful map for a real country.¹⁶³

This statement was made in 1950 by two psychiatric social workers operating at a child guidance clinic. What they saw as the deep and complex emotional relationships of their clients led them to consider that advice giving or attempts to change attitudes would be useless and potentially harmful.¹⁶⁴ In 1954 the psychiatric social worker Claire Britton similarly warned that , casework techniques were 'only ways of doing things within the framework of a professional relationship'. She warned that if these techniques were 'allowed to harden' they would 'soon cease to be effective instruments and become weapons of defence, or even attack, in the hands of those who use them.'¹⁶⁵

The author of an article entitled 'The Psychopathology of Inter-Clinic Conferences' also expressed these issues of hidden and coercive power. Of the much touted child guidance inter-professional approach, the author highlighted instead the conflict between disciplines, which he attributed to the emotional aspects of professional

¹⁶³ F. Lo-Beer and C. J. Iggulden, 'Thoughts Suggested by Psychiatric Social Workers' Interviews with Mothers and Children', *British Journal of Psychiatric Social Work* 2 No.3 1950 44-46, p46.

¹⁶⁴ F. Lo-Beer and C. J. Iggulden, 'Thoughts Suggested by Psychiatric Social Workers' Interviews with Mothers and Children', p45.

¹⁶⁵ Clare Britton, 'Casework Techniques in the Childcare Services', *Case Conference* 1 No.9 January 1955, reprinted in Eileen Younghusband (ed) *New Developments in Casework: Readings in Social Work, Volume 2* (London: George Allen & Unwin, 1966) 135-154. Quotes at p136 and p135 respectively.

relationships mitigating against full, open communication. He noted that at conferences the disciplines mixed very little. When, at regional conferences, each discipline had a separate sectional meeting, those who attended an inappropriate group by mistake were met, he remarked, with a 'gleeful and adolescent attitude of exclusion.'¹⁶⁶ At the 1948 Congress, mental hygienists had utilized small group discussion based on group therapy ideas. These, it was hoped, would unite the disparate disciplines and provide a community of common purpose. But, as we have seen, they soon encountered inter-personal and professional rivalries that belied their authoritative pronouncements of expertise in constructing 'healthy' personalities and relationships which it was essential to provide to all areas of 'administration, legislation and political action.'¹⁶⁷ In similar vein, this author described the way in which formal satisfaction with inter-clinic conferences was expressed during their progress, whilst underlying disputes and discontent were only revealed privately afterwards. He related these tensions directly to the relative satisfactions of power derived by membership of each profession and speculated upon what these might entail:

The psychiatrists have the most obvious satisfaction from power at an administrative and decision-making level. The psychologists feel power and draw satisfaction from their ability (real or supposed) to predict certain aspects of behaviour. At first sight the psychiatric social workers appear to withdraw deliberately from power satisfactions; but it seems fair to say that the assumed

¹⁶⁶ Christopher Beedell, 'The Psychopathology of Inter-Clinic Conferences', *British Journal of Psychiatric Social Work* 4 No.1 1957 24-28, p25.

¹⁶⁷ See chapter four, p151-152.

role of unsurprised, and by implication omniscient, listener has the same sort of power satisfaction attached to it as that of the most bigoted behaviourist.¹⁶⁸

One of the issues that this author was criticizing was that, for all their self-professed claims to expertise in 'human relations' many mental hygienists recognized such factors in theory only to pass over them in practice. The point, here, is precisely not just the fact that many mental hygienists' met with such 'defences', 'resistances', and prejudices in their own relational milieu. This in itself does not deligitimize their work or the problematic upon which it was based. Rather, it is that, having encountered these factors, many mental hygienists still failed to confront them as central issues or reflect on the ramifications of their existence for the claimed 'expertise in human relations' that they applied to others. Nevertheless, it should be emphasized that these criticisms were self-reflexive criticisms by some mental hygienists themselves. Indeed, this self-questioning was actually driven by the nature of the problematic that they deployed.

Hospital scandals, Patients' Voices, and Emotional Relations.

These ramifications of analyzing the emotional-relational milieu generally remained contained at the level of the therapeutic encounter. Psychiatric patients and relatives of mentally ill or handicapped people, for instance, only began to be heard at NAMH conferences from the mid-1960's. These opportunities themselves had been extremely limited to begin with. In 1964 the annual conference had included an expert panel,

¹⁶⁸ Christopher Beedell, 'The Psychopathology of Inter-Clinic Conferences', p28.

amongst whom was D.V. Martin. The panel commented on abbreviated transcripts of the opinions of relatives of mental patients.¹⁶⁹ In fact one of the first expressions of psychiatric patients' own feelings and experiences of the mental health services was a pretend one. A NAMH conference at the end of the 1960's employed actors to play the part of patients. These were planted in the audience so that they could 'spontaneously' stand up and express their views. The tactic appears to have met with consternation and some anger amongst the audience mostly made up of mental health professionals. Some were so taken in by the charade that they deplored the outrageous exploitation of vulnerable patients.¹⁷⁰ However, another NAMH conference, at the end of the 1960's, arranged for several real relatives and patients to be given the opportunity to speak from the platform.¹⁷¹

Along side these developments a series of hospital scandals broke from the mid-1960's. These appeared to underline the need for, not only increased funding and better facilities, but also the kind of reflexive care and treatment developed through attention to the primacy of emotional relationships. A letter published in the *Times* in November 1965 triggered media and political debate on the condition and treatment of patients in mental hospitals.¹⁷² In 1967 a book, *Sans Everything: A Case to Answer*, based on responses to this letter and other evidence (mostly from nurses and social workers), charged that serious abuse and neglect had taken place in specific

¹⁶⁹ NAMH, 'The Whole truth About Care of the Mentally Disordered', *Mental Health* 23 No.2 April 1964 43-49, p45-6. In 1961 NAMH had similarly played tape recordings at its annual conference which discussed by an expert panel. But these were extracts of 'typical opinions and prejudices' of the public. See, *Mental Health* Vol 20 No. 1 Spring 1961, p15.

¹⁷⁰ 'Dramatic charade', NAMH, Annual Report, 1969 – 1970, p10.

¹⁷¹ 'Consumer Panel', NAMH, *New Ways with Old Problems: Report of the Annual Conference 1969* (London: NAMH, 1969) 20-38.

¹⁷² For an outline of these scandals and their effects see, John Martin, *Hospitals in Trouble* (London: Basil Blackwell, 1984).

hospitals.¹⁷³ Additional chapters, by various experts in the field, proposed reforms and legislative changes. *Sans Everything* prompted Kenneth Robinson, the then Minister of health, to appoint committees of enquiry to investigate the allegations. He expressed his doubts about the validity of the accounts but assured nurses who made complaints that they would not be subject to reprisals. The reports of the inquiries, published in a white paper in 1968, largely dismissed the allegations as inaccurate and often the product of distorted and 'overly-emotional' accounts. In a statement on the white paper Kenneth Robinson called the allegations 'totally unfounded or grossly exaggerated'. And he lamented the effect on public attitudes to mental hospital care.¹⁷⁴ Robinson had long been closely involved with the NAMH and, in these assertions, was largely repeating his response to the NCCL's criticisms of mental deficiency institutions in the 1950's. The NAMH had publicly supported this view.¹⁷⁵ But this time the NAMH's response was different. It refused to accept the Minister's interpretation and pointed out that in only three of the cases were the allegations found to be disproved. It argued that management and administrative organization as well as staff training and attitudes were all deficient.¹⁷⁶

In fact, several people, closely associated with the NAMH had contributed to *Sans Everything*.¹⁷⁷ Russell Barton, for instance, provided a foreword in which he criticized mental institutions as developing powerful defence mechanisms and producing 'neurotic' misplaced loyalty amongst staff. The result, he argued, was that

¹⁷³ Barbara Robb (ed), *Sans Everything: A Case to Answer* (London: Thomas Nelson & Sons Ltd, 1967).

¹⁷⁴ House of Commons Debs, 9th July 1968.

¹⁷⁵ See chapter four.

¹⁷⁶ NAMH Annual Report, 1967-68, p13.

¹⁷⁷ The journalist C.H. Rolph, closely involved with the NAMH since the 1950's, contributed an article criticizing the Court of Protection for its inability to 'protect the defenceless invalid against physical discomfort, emotional exploitation and deprivation, indifference, exasperation and neglect.'; C.H. Rolph, 'Cruelty in the Old People's Ward' in, Barbara Robb (ed), *Sans Everything: A Case to Answer* 3-7, p3. This had previously been published by the NAMH in its journal *Mental Health*.

justified criticisms of practice and allegations of abuse were, dismissed, outright denied, or their authors discredited as mentally unstable, over zealous or motivated by malice.¹⁷⁸ A year later, he was cited in the *Observer* as saying that psychiatric hospitals were increasingly becoming like prison camps. He claimed that drugs were being used to accommodate patients to intolerable surroundings instead of helping to treat emotional disorders.¹⁷⁹

In 1968 Ann Shearer, a journalist for the *Guardian*, published a damning article about her visit to a sub-normality hospital. She wrote of having found children locked in a room covered in urine and excrement, which the children walked in and ate. In the resulting correspondence one researcher responded that her recent research had revealed no evidence of such squalor. But Roy King replied that he and his colleagues Jack Tizard and Norma Raynes' four-year comparative study of institutions revealed 'abundant evidence' that such circumstances were frequent.¹⁸⁰ In the same year, Peter Mittler, head of the Hester Adrian Centre in Manchester set up with the help of the NAMH, wrote an article for the latter's journal surveying the mental health services. In it he emphasized that many inmates of mental and subnormality hospitals did not need 'medical or nursing attention or supervision'. Some of the worst symptoms of chronic disorders, he stated, were the result of 'impersonal institutional organisation'. Early treatment and a therapeutic community approach, he maintained, were the principal means to combat this.¹⁸¹ The very next year the report of the committee of enquiry into allegations of ill treatment and misconduct at Ely hospital for mentally handicapped people was published. It was published in full and

¹⁷⁸ Russell Barton, 'Foreword' in, Barbara Robb (ed), *Sans Everything: A Case to Answer* ix-xi.

¹⁷⁹ Cited in *Mental Health* Summer 1968, p36-37.

¹⁸⁰ Cited in *Mental Health* Summer 1968, p37.

¹⁸¹ Peter Mittler, 'The State of the Nation', *Mental Health* Summer 1968, 2-3, p3.

forcefully reiterated the relational deprivation and abuse that could be experienced in mental subnormality hospitals.

The patients and relatives who spoke at the NAMH conference in 1969 expressed experiences that reinforced these images of hospital care. But their views also mirrored central elements of the emotional-relational problematic that had so significantly brought into question problems of authority, hierarchy and medical power.

Two speakers spoke as parents of children diagnosed with mental handicap. Both of them reported on their children's experience of relatively short stays in hospital or other residential care.¹⁸² The parents had found leaving their children traumatic and the children themselves had displayed seriously disturbed behaviour during and after these stays. One mother reported that her son's extreme debility and unresponsive behaviour had been put down, by a psychiatrist, simply to his 'defence against boredom.'¹⁸³ The mother, however, emphasized the emotional difficulties her son experienced in being separated from his parents, coupled with inadequate care and the poverty of the relational environment at the hospital.

A father of a child diagnosed as a Mongol (now termed Downs Syndrome) told of how a young doctor broke hospital policy by informing him of the diagnosis soon after his wife gave birth. The father was left to tell his wife alone, and he noted that the doctor had only risked telling him straight away because he considered the father 'intelligent'. The father was left wondering how long senior doctors would have been

¹⁸² 'Consumer Panel', Charles Hannam 30-31, p31 and Jean Slee-Smith 31-34, p32-3.

¹⁸³ 'Consumer Panel', Jean Slee-Smith, p33.

prepared to leave him and his wife in ignorance of the situation and without support. He remarked that the motives were unclear, but suspected that they were 'devices to protect the medical profession from emotional stress and involvement.'¹⁸⁴

All of those speakers who had been patients in psychiatric hospitals denounced the rigid hierarchy and control.¹⁸⁵ Stifling organizational procedures and rules of behaviour were criticized. Similarly, what was seen as unnecessarily close surveillance by nurses. But these criticisms were not simply made in the name of a right to liberty, and freedom from restraint, on the part of mental patients. They were considered by the patients themselves to be unhelpful to their recovery and mental well-being. These patients considered emotional relationships to be critical to their care and to their continued rehabilitation once back in the community.

One patient, diagnosed with schizophrenia, contrasted this traditional hospital organization with his experience of living on an experimental ward called Villa 21. This was a therapeutic community style experiment at Shenley mental hospital. Attendance on the ward was voluntary and patients had the choice of refusing treatment. An attempt was made to provide a close one-to-one relationship with a member of staff from a multi-disciplinary team. The ward was run democratically with patients having communal responsibility.¹⁸⁶ This speaker contrasted, what he saw as the more 'natural, human atmosphere of the place', with the restrained, regimented orthodox ward from which he had come, which was dominated by the

¹⁸⁴ 'Consumer Panel', Charles Hannam, p30.

¹⁸⁵ 'Consumer Panel', Clare Marc Wallace, p24-26, 'Mr G', p26-28, Diana Williams, p28-29.

¹⁸⁶ Anthony S. David, 'Books Reconsidered; Sanity, Madness and the Family: R.D.Laing and A. Esterson', *British Journal of Psychiatry* (1986) 149 379-381; Aaron Esterson, David Cooper, R.D. Laing, 'Results of Family Oriented Therapy with Hospitalized Schizophrenics', *British Medical Journal* 2 1965 1462-1465.

'watchful eyes of white-coated nurses.'¹⁸⁷ He felt it a great relief to meet with staff on what felt like equal human terms. This was particularly facilitated by staff relinquishing their uniforms, taking their meals with the patients, and dispensing with a separate staff room. Associated with this, unrestricted visits by people from outside the hospital, as well as from other wards, were actively encouraged and considered a vital aspect of therapy. The speaker expressed the value of these visits and the usefulness of the open discussions in which visitors could take part. He was of the opinion that visitors themselves also benefited from the experience.¹⁸⁸

Villa 21 was, in fact, developed by the psychiatrist David Cooper. He had collaborated with R.D. Laing on this work and, by 1968, coined the term anti-psychiatry.¹⁸⁹ As has already been mentioned, some critics of the rights strategy adopted by NAMH in the 1970's have cited anti-psychiatry as an important influence, using this to suggest the direct opposition of this rights policy to the psychiatric system and the concept of mental illness. However, as we can see, the resemblances between Villa 21 and central elements developed via the emotional-relational problematic are clear enough. Indeed, it is worth noting that there were close associations between the mental hygiene frame of reference and the early views expressed by R.D. Laing.¹⁹⁰ Like Goffman, Laing has been cast as an anti-psychiatrist. As I mentioned earlier, some, such as Nikolas Rose, have maintained

¹⁸⁷ 'Consumer Panel, 'Mr G', p26.

¹⁸⁸ 'Consumer Panel, 'Mr G', p27.

¹⁸⁹ David Cooper, *Psychiatry and Anti-Psychiatry* (St Albans: Paladin, 1970). Laing never accepted the label for himself and never really forgave Cooper for saddling him with it. Laing has nevertheless become closely associated with the term.

¹⁹⁰ See, for instance, the psychiatrist T. Ferguson Rodger's speech to a NAMH conference in 1956, in which he described many of the essentials of, what I have termed, the mental hygiene problematic, and associated early research by Laing and colleagues with it; T. Ferguson Rodger, 'Personal Responsibility and the Mentally Disabled', NAMH, *Mental Health and Personal Responsibility, Proceedings of a Conference held at the Royal Hall, Harrogate 12th and 13th April, 1956* (London: NAMH, 1956) 103-110, p106.

that this 'movement' informed NAMH's later turn to asserting the rights of patients. They suggest that both anti-psychiatry and rights were adamantly against the psychiatric system. We have seen that, in fact, Goffman's work was influential with notable mental hygienists. And, though Laing appears never to have been so well received, his early work too expresses many of the prominent elements of the mental hygiene problematic. For example, a speech he gave to a NAMH conference in 1966 reiterated the, by now common description in child guidance and other areas associated with mental hygiene, of the patient as a localized expression of a disturbance in relationships in the wider family.¹⁹¹ Though delivered in his own inimitable style, his description of good and bad therapeutic treatment was perfectly in keeping with the generality of reflective approaches we have already considered in this section. Laing decried the 'binary role system' of the hospital that separated staff and patients. Instead he promoted a multi-disciplinary team approach with the primary task centred on 'untangling the knots' in the field of human relationships. His advocacy that psychiatrists must learn from the theoretical models of anthropologists and sociologists simply reiterated the aims of mental hygienists expressed since the Second World War.¹⁹²

One speaker at the conference was a psychiatric nurse and also a diagnosed schizophrenic who had been hospitalized several times. She described how many of the elements of hierarchy and control were exemplified in electro-convulsive treatment (ECT). She herself had received the treatment eighty times. Some of these had been given 'straight', without anaesthetic. She reported how this was sometimes justified as a means to 'save time' and, at others considered by staff as a method of

¹⁹¹ R.D. Laing, speech on schizophrenia, NAMH, *The Heart of The Matter: Report of the Annual Conference, 1966* (London: NAMH, 1966) 74-78. and discussion 85-92, p 77 and 90.

¹⁹² R.D. Laing, speech on schizophrenia, p77.

punishment.¹⁹³ As we have seen, these issues had been raised at therapeutic community experiments. She, and another of the speakers, reiterated what these approaches had revealed; patients' emotional experience of ECT was often one of extreme fear and a sense of enforced indignity. They were also well aware that it could sometimes be used as punishment.¹⁹⁴ All of these factors were considered, by patients themselves, to be detrimental to their well-being and therapy.

Under the old moral therapy problematic patients were either recalcitrant or cured but never able to legitimately contest either their definition or the therapeutic approach. The emotional-relational frame of reference had undone this. Therapeutic measures could no longer legitimately be simply measured in terms of the doctor or staff's perception of the patient's response. The speakers at this conference wanted to be listened to as people whose experience was a valid aspect of knowledge about the value and effect of treatment. Those professionals reflecting on the therapeutic importance of dynamic emotional relationships supported this. Thus the psychiatrist J.H. Kahn introduced these speakers by emphasizing the commonality of feelings and experiences between those diagnosed as mentally ill and others. He remarked: 'Mentally ill persons have scarcely been allowed to give expression to the normal part of their personalities. When they give descriptions of their own experiences, they often meet with what Goffman has called the "institutional smirk"', which means, 'Yes, that's what you think you mean, but we know better'.¹⁹⁵

¹⁹³ 'Consumer Panel', Clare Marc Wallace, p24 and 25.

¹⁹⁴ 'Consumer Panel', Clare Marc Wallace, p25, Diana Williams, p28

¹⁹⁵ 'Consumer Panel', J.H. Kahn, Chairman's introduction to consumer panel session, p20.

Chapter Six: Emotional Relations Consolidated.

Introduction

This chapter discusses MIND's use of legal rights during the 1970's and 80's. The most commented on aspect of this work has been MIND's proposals for the reform of the 1959 Mental Health Act. I shall not focus on this campaign here. Instead, I want to discuss MIND's rights strategy in general and analyze the ways in which I believe it was fundamentally imbued with transformations in the conceptualization and treatment of mental troubles that I have outlined in this thesis. Commentators on MIND's activity in these years have represented it as a radical break with the organization's past. Associated with this view has been a characterization of its approach as based around the traditional civil libertarian focus of protecting the liberty of the subject. This chapter shows the inadequacy of these representations. I base my discussion around Nikolas Rose's contemporary attack on MIND's rights strategy. His was a sustained and theoretically sophisticated assault. My intention is not to arbitrate over the veracity or political and legislative consequences of MIND's rights strategy, but to show that Nikolas Rose's characterization of MIND's rights strategy cannot be substantiated. MIND was not simply colonized by an external discourse of civil libertarianism. In substantial measure it was informed by the discourse of emotionality, and its ramifications, that had been developed under the rubric of mental hygiene.

The rights strategy: A 'classical' civil libertarian break with MIND's past?

It was at the turn of the 1970's that the NAMH made what appeared to be a radical shift of approach. The organization gave itself the 'brand name' MIND and adopted a role as a pressure group campaigning for patient rights.¹ This shift has been universally portrayed by supporters and critics alike as a radical break with the organization's past.² The NAMH annual report for 1969-70 announced that the Association would be launching a 'major' campaign in order to raise the profile of mental health problems and in particular to highlight the problems of institutional care and of insufficient provision within the community. This campaign was to last three years and to be directed by the Norwich MP David Ennals, a former Labour Minister of Health.³ With the appointment of a new Director, Tony Smythe, on the 1st of January 1974, a more legalistically conceived notion of patient rights for the mentally ill was single-mindedly pursued by the association.⁴ Smythe had previously been Director of the NCCL, apparently playing a large part in turning the fortunes of the organisation around.⁵ He had also spent some time acting as a Field Director for the American Council of Civil Liberties.⁶ In the same year as Smythe's appointment as Director of MIND, the organization set up a multi-disciplinary working party to review the workings of the 1959 Mental Health Act.. The following year it appointed

¹ Though most often written in capitals the name is not an acronym. Nor did it replace the organization's official title.

² Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990's* (London: The Athlone Press, 1993); Clive Unsworth; *The Politics of Mental Health Legislation* (Oxford: Oxford University Press, 1987).

³ NAMH *Annual Report 1969-70*, p5. Ennals was subsequently to become Minister for Health in the 1974-9 Labour Government.

⁴ MIND, *Annual Report 1973-1974*.

⁵ Brian Dyson, *Liberty in Britain, 1934-1994 :A Diamond Jubilee History of the National Council of Civil Liberties* (London : Civil Liberties Trust, 1994), p43

⁶ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990's* (London: The Athlone Press, 1993), p200.

Larry Gostin, an American civil rights lawyer, to 'draw together the threads' and draft a report that would recommend changes to the Department of Health and Social Security.⁷ Much of the commentary on MIND's activity is based on Gostin's work.⁸ MIND's rights strategy, however, needs to be understood in a fuller context. Rights principles informed the policies and practice of the organization as a whole. And these principles themselves, I argue, were substantially underpinned by the problematic employed by mental hygienists and the consequences it engendered.

The consensus view of MIND's rights strategy as a radical break with the organization's past is connected with the perception of this strategy as classically civil libertarian. Indeed, many have drawn direct parallels between the legal rights approach pursued by MIND in the 1970's and 80's and nineteenth century civil libertarian challenges to psychiatry.⁹ The 1890 Lunacy Act, for example, is generally regarded as a 'triumph of legalism', in prioritising and protecting civil rights over psychiatric care and detention.¹⁰ The influence of legal advocacy for mental patients in the United States has also been emphasized. But both these influences have generally been invoked in order to characterize the approach as framing the treatment of mentally ill people in terms of the deprivation of liberty.¹¹ There was, it was argued, a fundamental dichotomy and opposition between the interests of civil libertarianism and of psychiatry.¹² Critics maintained that the rights approach in

⁷ NAMH Annual Report 1974-1975, p5

⁸ Nikolas Rose, 'Law, Rights and Psychiatry'; and, 'Unreasonable Rights: Mental Illness and the Limits of the Law'; Kathleen Jones, *Asylums and After*.

⁹ Kathleen Jones, *Asylums and After*; Peter Sedgwick, *Psycho Politics*, p213-4; Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Oxford University Press, 1987), p4

¹⁰ The phrase is from K Jones, *Asylums and After*, title to Chapter 6. See also Vicki Coppock and John Hopton; *Critical Perspectives on Mental Health* (London : Routledge, 2000), p52

¹¹ Kathleen Jones; *Asylums and After*, p203.

¹² Anthony Clare, 'Can The Law Reform Psychiatry?', *Mind Out* 48 (1981) p17.

general represented an unnecessary obstacle to the therapeutic endeavour¹³ or that such approaches could only deal with the misuse of psychiatric power and were thus unable to approach the structural aspects of that power.¹⁴ Others, on the other hand, argued that the rights emphasis in mental health represented a welcome return to legalism in as much as it accentuated control by statute and prioritized the legal rights of the patient.¹⁵

One of those who published a particularly vehement attack on the rights strategy pursued by MIND was the sociologist Nikolas Rose.¹⁶ He did not contextualise MIND's adoption of a rights based focus with the organization's own history, but, in effect, cast it as a colonization of a mental health charity by a separate discourse of civil rights. Similarly to other critics of the rights approach to mental health, he too emphasized that a central component was its conception of the treatment of mental illness principally in terms of the deprivation of liberty. For him, the strategy was fundamentally based around what he considered the classical civil libertarian position of the defence of individual liberty. However, Rose's argument entailed a fundamental twist compared to other critics. He claimed that MIND was deliberately placing itself in opposition to the psychiatric profession. But in fact, he maintained, it only served, paradoxically, to further extend and 'modernize' the psychiatric remit. The core of his criticism was based on what he saw as the shared fundamental imperatives of civil libertarianism and the psychiatric discipline. Civil libertarianism,

¹³ Jones; *Asylums and After*. See also, Anthony Clare; *Psychiatry in Dissent : Controversial Issues in Thought and Practice* (2nd ed) London : Tavistock, 1980), chapter 8.

¹⁴ Peter Sedgwick; *Psycho Politics*, p217-219.

¹⁵ Philip Bean, *Mental Illness Changes and Trends* (London : John Wiley & Sons Ltd, 1983), p2 and p180-182.

¹⁶ Nikolas Rose, 'Unreasonable Rights : Mental Illness and the Limits of the Law', *Journal of Law and Society*, 12 1985, p199-219; Nikolas Rose, 'Law, Rights and Psychiatry', in Nikolas Rose and Peter Miller, *The Power of Psychiatry* (Cambridge : Polity Press, 1986) 177-213.

he argued, appeared to be attacking the 'social control' elements of psychiatry. He argued, however, that both civil libertarianism and psychiatry had developed 'in the same transformation of ... rationality that gave birth to the concept of the individual free to choose.'¹⁷ In consequence they both were enmeshed within a liberal moral humanism and a bourgeois ideology of individualism.¹⁸ For Rose, psychiatry and civil rights both operated in terms of a contractual notion of 'the self'. Their objectives were the same; to produce and maintain the autonomous, private monad, situated within a community of other private monads who entered into relations with one another through free contract. Following Foucault, Rose pointed out that the therapeutic techniques of psychiatry were aimed at the reconstruction of 'malfunctioning' individuals, and that the philosophical doctrine of individual rights and fundamental liberties, had developed within the same historical process of individualization. Just as liberal doctrines of liberty, equality and freedom of choice rested on a concept of the autonomous individual, so too did techniques of social management, assessment, systematic knowledge and therapy. In fact the nineteenth-century could be considered the epitome of moral, social and economic doctrines of political economy. The market governed by private contracts between atomistic autonomous individuals: Free citizens with rights and duties.¹⁹

For Rose, then, history objectively showed that civil liberties and psychiatry shared a conception of the citizen as encapsulated, autonomous and privatized. However, such a view suggests a rather static view of psychiatry and civil liberties. This is particularly surprising with regard to psychiatry since Rose was, at this time (and

¹⁷ Nikolas Rose, 'Law, Rights and Psychiatry', p200-201.

¹⁸ Nikolas Rose, 'Law, Rights and Psychiatry', p200-202.

¹⁹ Nikolas Rose, 'Law, Rights and Psychiatry', p201.

since), tracing the contours of the disciplines' extension outwards, into society, to embrace newer disciplines of 'psy' and develop fresh techniques of intervention. Moreover, this common assumption of the static nature of civil libertarian discourse has led to some assertions about the interaction between civil rights arguments and psychiatry which could be criticized as lacking in analytical rigour. Thus, for instance, Clive Unsworth has suggested that legalism was 'temporarily dormant' during the passage of the 1959 Mental Health Act.²⁰ He has also suggested that legalism is resorted to 'at times of pessimism or uncertainty about how society should respond to the problems posed by mental disorder.'²¹ In his own article, Nikolas Rose offered a similar view. He speculated that the discourse of rights mistakenly appeared to offer 'a minimal line of defence for troubled times'.²² Such assertions, however, tend to evade analysis rather than provide it.

Of course, neither mental hygiene, nor any other discourse and practice can be understood as remaining static in their conceptions through time. Not only did theories of citizenship interact integrally with the project of mental hygiene throughout its history, but civil libertarian concerns altered and dovetailed with mental hygiene as the latter's problematic became reconfigured. I have tried to elaborate, in this thesis, what I see as some significant ways in which this configuration changed over time and some of the consequences of these changes. In the next section I argue that this enables a clearer understanding of why mental patients became the target of rights based strategies.

²⁰ Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987), p322.

²¹ Clive Unsworth, *The Politics of Mental Health Legislation*, p351.

²² Nikolas Rose, 'Law, Rights and Psychiatry', p211.

Why assert the civil and social status of mentally ill people?

What informed the civil libertarian desire to promote mental patients' civil status?

This is a central question about MIND's strategy that no commentator, including Nikolas Rose, has really questioned: Why was it that civil libertarianism turned to protecting the rights of the mentally ill? Why was it that civil rights activists sought to promote the civil and social status of a group of people traditionally segregated and termed 'insane' or 'mentally deficient'? One of the sources acknowledged, by both civil libertarians and their critics, as providing authority for promoting patients' rights was a nineteenth-century critique of 'state paternalism'. John Stuart Mill was one theorist cited by both camps. The basis of Mill's argument was that it was illegitimate for the state to exercise its power over citizens against their will. Rose pointed out, in a footnote to his article, the fact that Mill explicitly excluded the mentally incapacitated from his argument.²³ But neither he, nor the legal rights activists, however, have attempted to explain why, in that case, a civil libertarianism dedicated to protecting the individual rights of (by definition) sane citizens should have come to be applied to people considered insane. Why should civil and social status have been attributed to people considered largely incapable of exercising their rights? Rose appeared to agree with the bulk of psychiatrists who argued that the 'legalistic fictions of libertarians' bore little resemblance to the condition of patients experiencing delusional feelings or 'feelings of worthlessness arising from pathological guilt' – so why was a discourse of legal rights directed at mental patients?

²³ Nikolas Rose, 'Law, Rights and Psychiatry', p178-9, fn5.

The answer, according to critics of MIND's rights strategy such as Peter Sedgwick and Nikolas Rose, appears to be that MIND's activists naively accepted the most radical versions of sociological 'labelling' theory and 'anti-psychiatry', concluded that 'mental illness does not exist', and simply saw decarceration from psychiatric hospitals as the solution. But, these attributions appear, on the whole to have been used as pejorative rather than explanatory. In Rose's case, given his intent to historically contextualize the rights critique, it is surprising that he only provided the most limited description (I might say caricature) of the nebulous term 'anti-psychiatry', without unpacking what is meant by it and placing it in any historical context itself.²⁴ Thus, on his representation, 'anti-psychiatry' simply claimed that mental illness did not exist and that psychiatry worked in collusion with the state to control the citizenry. MIND's rights strategy was, supposedly, critically imbued with this view. Presumably with the influence in mind, Rose added, later in his article, a description of this 'rights' philosophy as it contrasted with 'therapeutic justice'. Rights philosophy claimed 'the right to be different' and therefore, 'A continuity [was] claimed between the involuntary confinement of the disturbing eccentric, the quarrelsome alcoholic or the socially disruptive derelict and the burning of witches, the pathologization of homosexuality and the confinement of political deviants in the Gulag Archipelago.'²⁵ This may be a reasonable description of Thomas Szasz's views, for example, but it does not appear to be a balanced picture of the rights strategies pursued by MIND.

²⁴ Nikolas Rose, 'Law, Rights and Psychiatry', p179. Such outright antipathy towards the anti-psychiatry movement (if indeed it can be described as a movement) was not expressed by Foucault. See, for instance, 'Psychiatric Power' in Paul Rabinow (ed), *Michel Foucault, Ethics, Subjectivity And Truth* (London: Allen Lane, 1994) 39-50.

²⁵ Nikolas Rose, 'Law, Rights and Psychiatry', p199.

Understanding why rights activists attempted to assert the civil rights of people with mental disorders becomes easier to understand, I think, if we bear in mind the effects produced by mental hygiene that I have elaborated. The civil libertarian strategy was not simply about protecting the privatized liberty of these people. I have shown that, from the interwar period, mental hygienists had developed a neo-moral therapy built around the delineation of stages of emotional development. Influenced by psychoanalysis, and a major vehicle of the 'new psychology', mental hygiene asserted that rational analysis had at last grasped the fact that emotional experience underlay all growth and adjustment. Humans were dynamic organisms. Emotional experience was a necessary component of this. To understand and craft these emotions was claimed to be both rationally enlightened and more 'humane'. In the process mental hygienists promoted, what I have termed a 'discourse of emotionality'. But this attention to emotional experience was no kindness for kindness' sake. It was not a recognition that emotional experience was important in its own right. And it was not applied universally. The aim was 'adjustment' to full, efficient, and progressive citizenship, construed as mental health. Thus mental hygienists were not just interested in the mental health of the individual. They were also interested in the health of society. For them the two went together. Mental hygienists based their expertise on their knowledge of histories of individual and societal development. They had conjoined idealist and biological descriptions of individual mental, and societal evolution. And on top of these, with the institutional establishment of mental hygiene, they had built a further history of emotional development. The 'social problems' of 'psycho-neuroses', on the one hand, and of 'mental deficiency', on the other, marked the polar distinctions between these concurrent and superimposed histories.

With mental hygienists' increasing attention to the details of inter-personal relationships, as the dynamic matrix in which emotional health and development was sustained, their notion of adjusting 'minds' transformed to one of seeking healthy social integration. This integration was construed in terms of inter-personal relationships. They contrasted impoverished emotional relationships that lead to isolation, and maladjustment or mental disorder, with adjusted relationships that produced health and social integration. Institutionalization became the epitome of the former, and the ideal of the therapeutic community became the emblem of the latter.

Looking at the relational context of emotional disturbance revealed a dynamic situation. Fixed diagnostic categories, and ideas of internal disease processes became subordinated to the dynamic effects of relationships. For a significant number of those working in mental hygiene, even certainty over which person in the matrix was ill, or maladjusted, became provisional and blurred. History had always provided a register through which mental hygienists could cement their normative prescriptions for mental health with prescriptions for social citizenship. But, as relational interaction in the present became increasingly the focus, patients' histories (biographical, or supra biographical) became contingent and uncertain. In the process, mental hygienists' presumed expertise in interpreting deviations from normed stages of development, became less clear and thrown into doubt. The discourse of emotionality dislocated itself from histories of individual and societal development that tied notions of mental health to full citizenship.

Rose maintains that anti-psychiatry was a strong influence on the rights approach in mental health, and implies that it simply denied the reality of mental illness. But, as we have seen, notable mental hygienists were receptive to Goffman's work (whom Rose cites as an 'anti-psychiatrist' in a footnote).²⁶ Moreover, Laing's early views were perfectly in keeping with the mental hygiene problematic and its ramifications. This itself had thrown notions of fixed disease entities into doubt, at the same time as it had suggested therapy should be constituted by flattened hierarchies, greater freedom and choice, and more open communication. With this came a simultaneous undermining of expert authority, and a belief that patients' emotional experience could constitute a knowledge and authority that could counter the knowledge and authority of the therapist.

Mental hygiene collapsed as a neo-moral therapy. Therapy had begun to recognize itself as a power relation. The expertise of mental hygiene was subverted at the same time as patients gained an ability (however partial) to speak outside the terms in which they had been defined. The emotional relational frame had significantly brought into question authority, hierarchy and medical power. An integral aspect of this was that attention to emotions in a relational milieu promoted a picture of similarities of human experience and response, and not of deficiency and difference.

Psychoanalysis and psychodynamic psychology were important elements in these re-configurations. I have noted that, what one recent writer has called the 'paradigm shift' in psychoanalysis was, in fact, part of a wider and concomitant shift integral to mental hygiene. And indeed, MIND appears to have appreciated some of this

²⁶ Nikolas Rose, 'Law, Rights and Psychiatry', p300, fn 6.

provenance regarding its promotion of patients' rights. In a 1974 report on psychotherapy it remarked:

... psychological treatments offer our best hope of increasing understanding of mental illness. The psychotherapeutic approach is to the patient as a whole person (including his physical make-up, for which physical treatment may be prescribed). It is this approach that has advanced our treatment of mental illness in the past – it was when psychoanalysts began to shed light on the individual's personality that the mentally ill ceased to be lunatics to be controlled and became people to be understood. Increased opportunities to control symptoms by drugs should not mean that psychotherapeutic skills are allowed to atrophy – or our patients will become lunatics again.²⁷

This continuity of normal and mentally disturbed experience, along with its fluctuating nature outlined through the mental hygiene also informed MIND and its desire to raise the social and civil status of mental patients. For instance the MIND Manifesto, produced as the policy basis for its early rights campaigning, noted that:

No boundaries mark out mental illness from mental health. Just as most mentally ill people have periods of stability and insight, so do 'normal' people experience feelings of irrational anxiety and depression. Mental illness may begin as a distortion and exaggeration of moods and emotions which we all

²⁷ NAMH, 'MIND Report no.12: Psychotherapy: 'Do we need more "talking treatments"?' (1974) p8. (Emphasis in the original).

share. So the mentally ill are not a separate race divorced from our world and our experience: they are 'we' and we are 'they'.²⁸

And, at the height of MIND's legal rights activity its Director, Tony Smythe, noted of the psychiatric system that:

Distinctions between individuals, their needs and behaviour, and between groups of people who share diagnostic labels or common problems are blurred to give the impression that mental patients are a uniform class somewhat separate from the mainstream of humanity.

The misapprehension that there is a firm dividing line between normality and abnormality diverts attention from individual needs and capacities and the dangers of discrimination, paternalism and oppression. In fact there is no such line - more a grey area which is not entered by many of us, occupied permanently by some or crossed regularly or spasmodically by others.²⁹

Indeed, the linkages with MIND's rights based campaigning were indicated on the opening page to part one of Larry Gostin's critique of the 1959 Mental Health Act, *A Human Condition*. This carried the following citation taken from the U.S. psychiatrist Harry Stack Sullivan: 'In most general terms, we are all much more simply human than otherwise, be we happy and successful, contented and detached, miserable and

²⁸ MIND Manifesto (1971), p1

²⁹ Tony Smythe; 'Mental Patients and Civil Liberties' in Peter Wallington (ed); *Civil Liberties in Conflict* (1984), p310-311

mentally disordered or whatever.³⁰ This remark is no simple 'idealism' of common humanity. Stack Sullivan was a key figure in the development of the 'science' of human relations. As I have noted, he played a significant role in the formation of 1948 International Congress on Mental Health, and in the drafting of its manifesto *Mental Health and World Citizenship*.³¹ In significant measure through the activities of mental hygiene, the mentally disordered had come to appear less a separate class, than one of us.

MIND's Rights Problematic: A Question of Liberty and Choice Versus Regulation and Restriction?

We have seen that Rose employed history as the means to argue that psychiatry and civil rights both operated in terms of the same notion of 'the self'. Their objectives were the same; to produce and maintain autonomous, encapsulated individuals, situated within a community of other private individuals who entered into relations with one another through free contract.³² He further argued that as such, psychiatry and civil libertarianism, in fact represented integrated forms of regulation. In consequence, he claimed:

It is clearly inadequate to appeal to some fundamental opposition of coercion to liberty, freedom and privacy. For even the demarcation of space of personal autonomy which is 'not the law's business' does not constitute an absence of regulation so much as a change in its modality.³³

³⁰ Larry O. Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975, Observations, Analysis and Proposals for Reform*, (London: Mind, 1975), p12.

³¹ See Chapter Four.

³² Nikolas Rose, 'Law, Rights and Psychiatry', p200-202 and p211.

³³ Nikolas Rose, *Unreasonable Rights: Mental Illness and the Limits of the Law*, p203.

This is Rose's central contention regarding MIND's rights campaigning. He characterized it as fundamentally placing individual liberty and choice in opposition to regulation and restriction. But, as we have seen, Rose maintained that psychiatry operated with the same conception of the 'free, rational, consistent, unified, choosing individual' as its intended end result. In consequence, he argued, since both psychiatry and rights campaigners pursued the same goal, rights arguments could not be logically employed as the means to determine whether intervention or non-intervention 'defended' the autonomy of the person. If the valued criteria was the 'autonomous choosing individual' then rights activists could not consistently argue against coercion and control since psychiatrists claimed to employ these measures in order to 're-construct' this autonomous individual.

This representation of MIND's rights strategy is misconceived. We have seen that a central element of the problematic of emotional relations was that freedom and choice were reconfigured. They were no longer simply the obverse of coercion and control. Nor were coercion and control now deemed the means through which a person (child or adult) might be inculcated with self-control, self-responsibility, and self-reliance. Freedom and choice were linked to emotional expression within a relational milieu – they were both a sign of mental health and the means to it. Freedom and choice were thus elements of social integration. The converse was isolation and separation from the matrix of human relations. Freedom and choice were no longer simply the intended end result of mental treatment they were intrinsic elements of the relational milieu in which mental health became manifest and therapy could take place.

MIND's Rights Strategy Represents an Opposition of 'Institutionalization' Versus Healthy Emotional Relations and Social Integration.

The fundamental opposition between freedom and choice on the one hand, and coercion and restraint on the other, that Rose wrongly claimed to be characteristic of MIND's rights activity can be more appropriately replaced with an alternative opposition; an opposition between institutionalization and healthy emotional relations. Mental hygienists had considered institutionalization to create, not only passive docility but also mental and social isolation. Central to this view was the notion that the condition of patients in mental hospitals could be significantly attributed to the quality of emotional relationships there, rather than to the symptoms of a disease process inside an isolated individual. It was the judgement that 'emotional affiliations'³⁴ were considered to be deteriorated under restrictive and authoritarian power structures that informed practices designed to combat or avoid institutionalization.

MIND's approach continued this. It should not be understood as an assertion of liberty and choice against psychiatric control and restraint. Rather, the contrast was between 'unhealthy' isolation, on the one hand, and 'healthy' integration on the other. The very first page to volume one of *A Human Condition* placed the community-based care that it promoted in contradistinction to institutionalization. 'There is a

³⁴ This is a phrase used by Nikolas Rose, to which I will return.

consensus of opinion among mental health professionals', it stated, 'that community-based care should, wherever possible, be preferred to confinement in traditional institutions.' It went on to elaborate that the 'poverty of the social environment' in traditional hospitals created a 'functional pathology' termed 'institutionalism'.³⁵ Institutionalism was correlated with isolation, withdrawal from relationships, apathy, dependence, and conformity. Community provision, in contrast, was correlated with social integration and participation.³⁶ Such contentions were in full conformity with those developed through the application of the emotional-relational problematic. And they continued, what had been a central tenet of NAMH, and mental hygiene in general, of developing early treatment, care, and rehabilitation in the community. Indeed it was growing discontent with the failure of successive governments to fund and statutorily enforce the extension of community care and treatment that partly spurred the NAMH's adoption of the campaigning label MIND and a rights approach in the 1970's and 80's. In 1974 MIND released a document criticizing the slow development of community provision by local authorities. It stated that, in its view, there was a mandatory obligation upon local authorities to provide care and after-care for people with mental disorders. The 1946 National Health Service Act had only provided local authorities with the discretionary power to provide this care. But MIND argued that both the 1959 Mental Health Act and the 1968 Health Services and Public Health Act had reinforced this power to the extent that it was now mandatory. On the basis of this view MIND signaled its decision to pursue test cases to firmly establish the legal right to community care.³⁷

³⁵ Larry O. Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975: Observations, analysis and proposals for reform* Volume 1 (London: MIND, 1975), p13.

³⁶ Larry O. Gostin, *A Human Condition*, p13-14.

³⁷ MIND, Report No.13, *Co-ordination or Chaos?: The Run-down of the Psychiatric Hospitals* (London: MIND, May 1974), p20-21 and 26. MIND cited a passage from Circular 22/59 of 7th August 1959 which read, '... the Minister ... hereby directs ... that ... arrangements shall be made by every

MIND emphasized that community provisions must avoid setting up 'mini-institutions'. Hostels should be 'homely' and integrated with the general community.³⁸ This was no assertion of a 'right to be different' outside of psychiatric control and coercion, as Rose asserted. On the contrary. In fact, MIND itself, accused the government of denying the reality of mental illness. Its 1974 report was critical of the government policy towards running down mental hospitals in favour of care in the community, remarking that: The Department of Health and Social Security 'appears to have shaped its policies on the assumption that chronic mental illness no longer exists.'³⁹

This distinction between the isolation and dependency seen to be created by large segregated mental institutions and the need for integrated community care sustaining supportive human relationships was expressed in MIND's 1976 'Home From Hospital' campaign. This campaign was launched the year following Larry Gostin's review of the 1959 Mental Health Act. MIND and the government estimated that between a third and a half of patients in mental hospitals could live in the community if they had somewhere suitable to live.⁴⁰ The aim was to increase accommodation in the community for these, and already discharged, ex-psychiatric patients. Many of these

local health authority for the purpose of the prevention of mental disorder and ... the care of persons suffering from mental disorder and the after care of such persons'. (p21).

³⁸ Alison Wertheimer, 'Co-ordination or Chaos – The Rundown of Psychiatric Hospitals', *Royal Society of Health Journal* July 1975 (reprint), p2-3.

³⁹ MIND, Report No.13, *Co-ordination or Chaos?: The Run-down of the Psychiatric Hospitals* (London: MIND, May 1974), p7.

⁴⁰ MIND, *MIND Campaign 1976: Help a Healthy Mind Leave Hospital* (pamphlet, 1976); MIND, *MIND 1976 Campaign, Home From Hospital: Progress and Results* (London: MIND, February 1977)

patients required continuing support in the community.⁴¹ MIND reported that patients often complained of isolation and loneliness after discharge. It maintained that:

Many of these patients will be severely institutionalised and while recognizing the reasons for this it is important not to assume that to place people in the community is to modify their institutionalised behaviour – 'Institutionalisation does not disappear when asylums walls fall down'.⁴²

In accordance with these assertions, MIND promoted a variety of accommodation and support options.⁴³ These included, day centers, boarding out schemes, and group homes.⁴⁴ MIND's local associations had pioneered the group home scheme through which selected patients could leave hospital and live together in small groups in the community. A NAMH working party on residential care set up in the early 1970s described the 'principle ingredients' of group homes as:

'The experience of group life and the opportunity to learn to live harmoniously in a small community in a somewhat sheltered situation... . As in a hostel, residents have the opportunity to learn from one another, to mix, and to make allowance for other people, but without resident staff to intervene. The individual must be ready to exercise his own choice within the daily routine and to manage with a degree of independence. The amount of supervision

⁴¹ MIND, Occasional Paper 5 - *Effective Community Care and the Mentally Ill: Back up Resources for GPs, Hostel Staff, Day Centre Staff and Others Caring for the Mentally Ill in the Community* (London: MIND, July 1976), p1.

⁴² MIND, Report No.13, *Co-ordination or Chaos?*, p7. (Emphasis in the original).

⁴³ MIND, *MIND Report: "Room to Let": A Report on Nine Social Services Lodging Schemes* (London: MIND, September 1976).

⁴⁴ 'Life Begins at Sixty Plus'; 'Wanted! More Landladies', 'Stepping Stones', *Mindout* No12. August 1975, 3-5; MIND, *MIND Report: "Room to Let"*, p1.

afforded by visiting social workers varies considerably but the opportunity for group interaction differentiates this form of care (than) that offered in flatlets or other sheltered accommodation. Generally the number of residents in a group home does not exceed eight.' ⁴⁵

According to Edith Morgan, NAMH's Local Associations organizer, it was the absence of staff and the residents' responsibility for their own affairs that were the distinctive features of group homes. But, placed in the context of changes in approaches to mental disorder based on the prioritization of human relational causations, we can see clearly the continuities of therapeutic endeavour. A specific aim of group homes was to achieve rehabilitation through enabling a shared life as similar as possible to a family environment.⁴⁶ It was argued that large houses with more than five or six people in them, were not suitable as they may lose their 'family atmosphere' and become a mini- institution. Group homes comprising mixed sexes were recommended for the same reason.⁴⁷ Flats and bed-sitters were believed to be unsuitable because they did not provide the necessary communication between people and it was considered there would be little community spirit. Relationships were the key to sustaining mental health. In fact although these homes emphasized the absence of staff, they nevertheless relied on both voluntary and professional intervention to a certain degree. The Sheffield Association for Mental Health, for example, opened two group homes in the early 1970s and by 1977 had four which were rented directly to their residents. Patients were prepared at the local hospital before they moved. The Local Association relied heavily on the Community Nursing Department to support

⁴⁵ Cited in speech by Edith Morgan to Camden Association for Mental Health, 20th March 1973. (Edith Morgan private papers).

⁴⁶ NAMH, *Starting and Running a Group Home*, p27.

⁴⁷ NAMH, *Starting and Running a Group Home*, p23.

them in the homes. By 1977, however, the Association was actively attempting to involve volunteers in the Homes in order to prevent them becoming 'mini-institutions', with less possibilities and more restrictions than inside the hospital.⁴⁸ In other words, this was to prevent the residents becoming institutionalized again.

Accompanying these developments of accommodation, MIND experimented with day-care and drop-in centers. Two of these were jointly run with the Tavistock Institute. The Brecknock Community Centre in North London was one of these. This project was aimed at providing non-institutional support in the community for people with different needs. It was located in an area with a large bed-sitter population and was intended to provide support for isolated people (as well as, those 'who may have been institutionalised for years) in a non- categorizing, non-labelling, informal environment.⁴⁹ The Junction Road Project, was also based in North London. MIND contended that the health, local authority, and education services all too often created 'over-dependent, long-term relationships' with their clients and rationalized these on the basis of organizational convenience.⁵⁰ This, in effect, represented an extension of the principles expressed by mental hygienists in their 1940's criticisms of residential childcare, and at the therapeutic community experiments. These had denounced care based around institutional convenience, claiming that they mitigated against the development of therapeutic emotional relations. The Junction Road Project hoped to alter the nature of the relationship between caregivers and clients. It intended to provide a community mental health project at a 'neighbourhood' level. The project

⁴⁸ Jane, Monach,, Address to MIND conference 'Rehab 77'. (Edith Morgan private papers).

⁴⁹ MIND, *Annual Report 1978-1979*, p14.; Joy Melville, 'Nobody Labels Us Here', *Mindout* No.40, May/June 1980, 14-16.

⁵⁰ MIND, *A New Deal for Mental Patients: MIND's Further Evidence to the Royal Commission on the National Health Service* (London: MIND, September 1978), p7.

provided an advice and information service, and supported self-help groups.⁵¹ A multi-disciplinary team provided the backbone of the project, with support from local volunteers.

The Goal of Healthy Emotional Relations and Social Integration Retained; Professional Expertise and Power Relations Questioned

With its altered frame of reference conceptualizing emotionality as a relational phenomena central to mental health, mental hygiene shifted its aims to promoting 'healthy' inter-personal relationships and social integration. MIND, then, can be seen to continue this imperative. But it can also be seen to express and consolidate the further ramifications of shifting therapeutic attention to the dynamics of inter-relational experience. From its early institution this altering of reference had reconfigured the rationale of voluntary treatment provision and, along with it, the value of freedom and choice. Simultaneously with this it had thrown into question authority and hierarchy. In consequence, not only did therapeutic expertise reveal itself to be a power relation, but in significant quarters, an engagement with the facts of this power relation became seen as a vital part of therapy. This constituted a subversion of mental hygiene's one-way neo-moral therapy. MIND was a beneficiary and elaborator of these processes. A problematic that conceived the manifestation of mental disorders, and their treatment, as located in an emotional relational milieu undermined professional expertise, questioned diagnostic categories and labels, and opened a space (however partial in the generality of therapeutic practice) in which

⁵¹ *Introducing the Junction Road Project* (Newsheet, May 1978). (MIND archive).

subject's *own* voices might question the power relations constituent of the social disciplining and treatment of mental troubles.

Rose completely ignores this. In his attack on the rights approach, he reduced MIND's strategy simply to a classic libertarian notion protecting people from invasion of their personality by hazardous and intrusive treatments. This view he portrayed as, 'grounded in a right to privacy, to control over one's own internal thoughts and feeling, and to protection from assaults, no matter how well-meaning their motivation.'⁵² He suggests an uncomplicated goal of establishing a right to control over one's feelings as if they were private and encapsulated. Rose's phrasing here is essentially an attempt to re-emphasise his main contention that the rights strategy sought, what is perceived to be the classic civil libertarian aim, of producing an autonomous, private monad, situated within a community of other private monads who enter into relations with one another through free contract.⁵³ They are self-encapsulated and so are their feelings.

Rose characterizes MIND as simply attempting to 'debunk' psychiatry whilst ironically only further promoting psychiatry's pervasive power of constituting privatized personalities capable of living autonomously in the community. In accordance with this contention, he maintains that, at the same time as it cynically disparaged the psychiatric profession, the rights approach naively and unquestioningly promoted, what he called, the 'professions of the social'. These professions – social work, psychotherapy, counseling – he considers to be simply extended and 'modernized' means to fabricate autonomous individuals.

⁵² Nikolas Rose, 'Law, Rights and Psychiatry', p199-200.

⁵³ Nikolas Rose, 'Law, Rights and Psychiatry', p211.

But this is a view that pays no regard to the questioning of power relations that informed the rights strategy. In fact, MIND's attention to physical treatments was not merely the classic civil libertarian one of protection from assault. Likewise, its promotion of social work and psychotherapy was by no means uncritical. I briefly discuss some examples of this below.

MIND's approach to Electro Convulsive Therapy (ECT) might appear to be a typical example of MIND's civil libertarian defence of the privatized encapsulated mind from invasion. But there was more to its stance than this. Though MIND was at the time often portrayed as taking an outright stand against ECT this was not the case.⁵⁴ Its concerns were centered on ECT's effectiveness as a treatment, its safety, and the patient's consent to treatment. But underlying, and informing, these issues lay the importance of emotional experience and power relations. The emotional-relational problematic deployed by mental hygienists had revealed the fluctuating manifestation of mental disorder. It had shown that patients unable to make decisions in certain life situations were quite capable of making decisions in others. Mental patients were not simply and wholly irrational. MIND applied this to ECT treatment. It re-asserted that: 'A patient may be "incompetent" to make decisions in one field but perfectly able to exercise choice in another.'⁵⁵

Moral therapists had originally considered the application of fear to be a useful therapeutic weapon in their armoury. Between the wars mental hygiene's neo-moral therapy had reconfigured this. Fear distorted emotional development and consequent

⁵⁴ MIND, *Policy Briefing Paper No.1: The Use of Electro-Convulsive Therapy (ECT)* (Xerox c.1980), p2. (MIND archive).

⁵⁵ MIND, *The Use of Electro-Convulsive Therapy*, p2.

mental stability. With the shift to pinpointing the fundamentals of mental health and disorder to the dynamics of emotional relationships the pervasiveness of patients' experience of fear regarding wide areas of care and treatment became revealed. As we have seen, the use of ECT was one particularly charged example of this. Moreover therapeutic community approaches had revealed its application often to be suffused with authority, hierarchical power and hidden desires for control and punishment. MIND's deputy director, John Barter, noted that large numbers of patients were afraid of ECT and many were adamant that they never wished to repeat the experience. This was a view supported by some, in letters written to MIND, and reiterated in some of MIND's publications.⁵⁶ Barter maintained that:

It is not only unwise, it is also high-handed to dismiss such fears as irrational, or part-and-parcel of the patient's mental illness. Fear is an unpleasant and damaging emotion. Creating or sustaining fear in mentally ill people would seem to the intelligent layman to be absurd and anti-therapeutic, as well as immoral.⁵⁷

And this emotional relation was understood as a power relation. Thus Barter attributed much of this insensitivity towards emotional experience to imbalances of power and rigid professional hierarchies. He linked these inequalities to the large, remote, segregated mental hospitals and their lack of integration in the wider community.⁵⁸ In this context, he remarked:

⁵⁶ Moses Laufer, , *Adolescent Disturbance and Breakdown* (Harmondsworth: Penguin and MIND, 1975), p77; *Mindout* No.7 October 1974. (Laufer had been involved with NAMH's Canford study in the early 1960's); *MINDOUT* No.7 October 1974, p4-5.

⁵⁷ John Barter, 'ECT – Treatment or Torture?', paper presented at L.M.G. Symposium, St. Thomas Hospital, 9th March 1978, p5. (MIND archive).

⁵⁸ John Barter, 'ECT – Treatment or Torture?', p3.

The freedom of psychiatrists to apply ECT to whom they will among compulsory patients, and informal patients who appear to be at grave risk, stands in stark contrast to the absence of freedom of patients to choose either their psychiatrist or their treatment.⁵⁹

In contrast to its concerns about ECT, MIND publicly promoted the wider deployment of psychotherapy. This was, in part, because many patients' clearly expressed their desire for this.⁶⁰ But, here again, what is evident in this is an awareness of the inherent, and potentially damaging power relations involved. MIND was by no means uncritical in its promotion of psychotherapy. It emphasized that psychotherapy should not be envisaged as a panacea, and that quality as well as quantity was required. In order to promote this it published a paper given by a child psychotherapist at its 1974 Inter-Clinic Child Guidance Conference. MIND cited this paper as a 'graphic description' of the quality to be aimed for, noting that the speaker;

... emphasised for a psychotherapist to try to understand the *patient's* sense of reality and not to impose his own external view. He also stressed that the psychotherapist – and indeed any professional – must not see himself as the healthy one and his patient as sick. He must be strong enough to recognise that the problems to which he is listening may very well strike a chord in his own background and cause a block in the relationship.⁶¹

⁵⁹ John Barter, 'ECT – Treatment or Torture?', p8.

⁶⁰ NAMH, 'MIND Report no.12: Psychotherapy: 'Do we need more "talking treatments"?' (1974).

⁶¹ MIND, Annual Report 1973-4, p6. MIND published this paper in its Occasional Papers series.

MIND's promotion of social work was informed by similar imperatives. For instance, in an address to the British Association of Social Workers conference in 1982, Larry Gostin chose to discuss the question, '...when does social work change from being a constructive and humanitarian support for vulnerable people in the community to an agency for social control?'⁶² Benevolent intentions did not entail an absence of power relations. MIND's approach to services for children also illuminates this. The organization believed that the primary aim of child psychiatric services was the 'prevention of further deterioration in each child and his family's mental health'. Residential care was to be considered an 'absolute last resort'.⁶³ But this was no naïve assertion of a right to privacy and freedom from control and restraint. A MIND working party, set up to offer recommendations to professionals on procedures for the assessment of child and family problems, was clear that assessment was, in and of itself, 'as potent a form of intervention in the life of a child as [was] any action undertaken in consequence of it'.⁶⁴ In Rose's terminology such assessment would represent one more element in 'techniques of regulation' constituent of the 'discretionary powers of the social', that he claimed advocates of rights promoted without the critical appraisal they directed to psychiatric medicine. But the MIND working party emphasized that, whether a person sought help of their own free will or without their consent (because they were perceived as a problem to themselves or others) assessment and the collection of facts were constituent of a relation of power. MIND was concerned to ensure that these forms of regulatory power were exposed as such. It based its recommendations on the need for effective multi-disciplinary co-

⁶² Larry Gostin 'Social Work or Social Control?' Opening address to BASW Conference 10/11/82, p1 (MIND Archives).

⁶³ MIND, *MIND's Comments on the Court Report on the Child Health Services: The Child Psychiatric Services* 24th August 1977, p3.

⁶⁴ MIND and Kings Fund Centre, *Assessment of Children and their Families* (London: MIND/Kings Fund, October 1975), p25.

operation, continuing professional training, and an 'unequivocal commitment' to listening to the wishes of children and parents. What is crucial here is that MIND was quite clear that attempts to prevent the removal of a child to residential care did not represent the absence of regulation and control. But they were also quite clear that these forms of regulation were (as they were in institutions) fundamentally *relations* of power. The working party remarked: 'The observer affects what he observes, and is himself affected by his own observations; and assessment entails a great deal more than mere observation.'⁶⁵ MIND used the concept of rights as a means to allow the voices of those most acutely and immediately affected by such power to be respected and heard. The professionals were part of the processes they sought to describe and act upon. They were to be required to acknowledge this, and thus to promote regulatory practices that were not simply one-way forms of power.

That Rose did not acknowledge these elements of MIND's rights strategy, or factor them into his consideration of its value, is exemplified by the subject of therapeutic communities.

MIND Promotes Therapeutic Communities

As we have seen, Rose considered that MIND's rights strategy paradoxically extended the power of psychiatry in its ongoing construction of autonomous, interiorized, individuals. He proposed, however, that, in contrast to the misconceived and self-

⁶⁵ MIND and Kings Fund Centre, *Assessment of Children and their Families*, p4.

defeating application of civil rights, other historical discourses, that propounded alternative values, might be remembered:

The ideals of community promoted both by the moral treatment of the last century and by the contemporary therapeutic-community movement certainly led to the development of profoundly moralizing institutions, but they also made thinkable a mode of support and care for distressed people that locates them within a matrix of emotional and practical affiliations, and that sees autonomy as a problem and not a solution. In a somewhat similar manner, the communitarian, mutual aid approach of Geel in Belgium, maintains the mentally distressed in a system of family placements linked together by structured collective support mechanisms⁶⁶

Rose claimed that he was not, in fact, advocating either, but simply pointing out that they were 'difficult to conceptualize within the horizon of the contractualization and autonomization of both rights discourse and contemporary society.'⁶⁷ This equivocation aside, there are several problems with this passage. In the above citation Rose places moral therapy and therapeutic communities in contradistinction to civil rights. And, indeed, he appears to group moral treatment and therapeutic communities together. These approaches are contrasted with the purported rights promotion of autonomy because they situate patients in a 'matrix of emotional and practical affiliations'. But there are problems with this passage that I want to emphasize here. As we have seen, nineteenth century moral therapy took a quite distinct view of emotionality to therapeutic approaches exemplified by therapeutic

⁶⁶ Nikolas Rose, 'Law, Rights and Psychiatry', p212.

⁶⁷ Nikolas Rose, 'Law, Rights and Psychiatry', p212.

communities. Indeed it is unclear why Rose wants to suggest that nineteenth-century moral therapy was not about the resurrection of an autonomous and encapsulated individual. This was clearly its aim.⁶⁸ Rose himself has noted of moral therapy:

This continual play of judgement had the objective of forcing the inmate to take into himself the role of judge, to internalize the moral order which constituted the asylum, to incorporate the rules and principles of that institutional space of morals into the moral space of his own character.⁶⁹

Surely this is a representation of moral therapy as considering 'autonomy as a solution.' Moreover, Rose has elsewhere been keen to stress that therapeutic communities were 'a profound strategy of normalization of maladjusted selves.' They should be understood, he has said, as coextensive with, 'the reconstitution of the patient as a person.'⁷⁰

However, analyzing mental hygiene as deploying a moral therapy problematic that shifted in its conceptualization over time, reveals the conceptualization of emotionality at therapeutic communities to be quite distinct. To recapitulate the specific difference regarding 'emotional affiliations': Under the terms of reference of moral therapy the patients' emotional sensitivity constituted a target through which the inculcation of self-control could be achieved. But, under the relational problematic

⁶⁸ Andrew T. Scull, *Museums of Madness: The Social Organization of Madness in 19th Century England* (London: Allen Lane, 1979); Porter, Roy, 'Shaping Psychiatric Knowledge: The Role of the Asylum' in, Roy Porter (ed) *Medicine in the Enlightenment* (Amsterdam: Clio Medica, 1995) 255-273; Porter, Roy; 'Madness and its Institutions', in, Andrew Wear (ed), *Madness in Society: Historical Essays*, (Cambridge: Cambridge University Press, 1992).

⁶⁹ Rose, Nikolas; *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939* (London: Routledge and Kegan Paul, 1985), p27.

⁷⁰ Nikolas Rose, 'The Discipline of Mental Health' in Rose and Miller *The Power of Psychiatry* (Cambridge: Polity Press, 1986), p74 and p77.

which imbued the therapeutic community approaches I have discussed, the patients' emotional experience, and the emotional milieu in general, were sources of knowledge that could potentially counter the therapists' power. David Clark who, as we have seen, was closely associated with NAMH, described the therapeutic community approaches of which he was an influential advocate, this way:

... any examination of any institution must include all the human beings in it; that staff have feelings, passions, intrigues, irrationalities and movements of the spirit as much as the patient, and further that these all interlock. ... the books on the hospital practice of an earlier era did not see this at all. The irrationalities of the patients could be noted, described, examined and analysed, but there was no suggestion that the staff's feelings and needs might contribute to it.⁷¹

Rose is quite wrong to separate therapeutic community approaches from MIND's rights strategy. In the 1960's NAMH had been involved in conferences and training with the Richmond Fellowship.⁷² This was the primary organization providing small scale therapeutic community care. MIND continued to be involved with the organization during the 1970's and 80's. Moreover, the Association of Therapeutic Communities, founded in 1972, held some of its regular conferences in conjunction with MIND.⁷³ When the therapeutic community at Henderson hospital, was threatened with closure, MIND was at the forefront of the campaign to keep it open. MIND argued that the therapeutic community model it used had conclusively

⁷¹ David H. Clark, *Social Therapy in Psychiatry* (Harmondsworth: Penguin, 1974), p50-51.

⁷² NAMH Annual Report 1967-68, p15; NAMH Annual Report 1968-9, p12.

⁷³ N.K., 'What Happened to the Therapeutic Community' in, Jones, K., (ed), *The Year Book of Social Policy in Britain 1975* (London: MacMillan, 1975). Chapter 9, 141-154, p152.

demonstrated an effective alternative to traditional drug treatment and physical intervention for personality disorder. MIND also praised the fact that its methods had been widely adopted in more conventional psychiatric institutions with the introduction of ward meetings and group discussions. Indeed, its training programmes had enabled staff of all disciplines to develop its practices and traditions at various settings throughout the country.⁷⁴ MIND itself organized workshops to spread, and explore, therapeutic community concepts. It noted that 'movement away from rigid treatment models' had led to great interest in the concept.⁷⁵

MIND provided residential care and education at two establishments operated on therapeutic community lines. Both of these were for children and young people. One had been opened in 1969, just prior to MIND's adoption of a rights basis for its work. The other was developed in 1975. That these projects were supported and promoted is notable in the context that MIND closed a number of its other residential care Homes. Some of these were closed on the grounds that they were too institutional and provided the wrong form of care. Here again MIND was adamant that committal to care rarely promoted either the personal interests or the mental health of children.⁷⁶ Its two educational and residential projects for children and young people represent attempts to grapple with these issues. I discuss these below.

⁷⁴ 'Proposed Temporary Closure of Henderson Hospital, Sutton – Mind's Response to the Consultative Paper Issued by the Merton, Sutton and Wandsworth Area Health Authority', 1979, p1-2. See also, 'Unique Mental Health Service Threatened with Closure: this highlights health authorities' irresponsible actions, warns MIND Director', *Mind Out* No.36, September/October 1979, p5.

⁷⁵ *Mindout* No.9, February 1975, p15.

⁷⁶ John Barter, 'Children at Risk', *Mindout* No.9 February 1975 6-7, p7; Laurie Taylor, Ron Lacey and Denis Bracken, *In Whose Best Interests? The Unjust Treatment of Children in Courts and Institutions*, (London: The Cobden Trust and MIND, 1980).

Feversham had opened in February 1969 as a residential school for children termed emotionally disturbed. From the start it was based on therapeutic community concepts derived in part from David Wills and Richard Balbernie, both of whom had operated experimental residential provision with the NAMH.⁷⁷ The children's residential arrangements essentially reiterated the principles of care promoted by mental hygienists and adopted by the Curtis Committee in the 1940's. The children's residential accommodation was divided into separate units of about eleven children. Each comprised separate bedrooms shared living room and kitchenette. It was intended that the children occupy the unit as 'a mixed sex, family group'. This was considered part of the therapeutic atmosphere of 'intensive experience in social relationships and in the development in social skills.'⁷⁸ Continuity of intimate emotional relationship with an individual member of staff was encouraged. One to one counseling services and group meetings took place, but these were now supplemented by 'spontaneous' counseling based around day-to-day life situations as they occurred.⁷⁹

The medical notion of 'illness' and 'cure' was replaced with the terminology of 'better or more appropriate adjustment.'⁸⁰ As we have seen, the terminology of adjustment was central to mental hygienist's moral therapy problematic between the wars. But at Feversham, as one would expect, it expressed the altered problematic that construed maladjustment in terms of a matrix of dynamic emotional relationships. The repudiation of medical terminology, in fact, reflects NAMH's criticisms of childcare

⁷⁷ Roger Stansfield, 'A Special Kind of School', *Mindout* No.23 July/August 1977 5-7, p5. An acknowledgement of influence also made by MIND about its approach to child care in general. See, Editorial, *Mindout* No.9 February 1975, p3.

⁷⁸ MIND, *Feversham* (Newcastle, November 1982), (Publicity and information brochure), p13.

⁷⁹ Roger Stansfield, 'A Special Kind of School', p6-7.

⁸⁰ Roger Stansfield, 'A Special Kind of School', *Mindout* No.23 July/August 1977 5-7, p5.

in the 1940's. This had cast the medical model as too focused on physical care and thus harmful to children's emotional health and development which was situated within the relational context of care. In the 1970's and 80's MIND expressed such views more forthrightly. In 1975 MIND remarked that: ' "Treatment" implies the presence of an illness but there is no evidence generally available to suggest that the overwhelming majority of deprived or delinquent children are ill.'⁸¹ It argued that 'ill-founded diagnostic labels, such as delinquency' were more appropriate descriptions of the 'child's social world than of the child's inherent personal difficulties.'⁸² Instead, MIND maintained, there should be an emphasis on fostering social skills and interests. At the same time it re-asserted the importance of ensuring that care fostered good emotional relationships. It argued that children could be condemned to delinquency by institutional forms of punishment and control that only served to reinforce feelings of rejection and failure.⁸³ The Pimlico school in London was cited as an example of good practice. Here staff were seconded to give part of their time to the integrated school counseling service so that they might enhance their understanding of pupils' emotional needs.⁸⁴

A large proportion of the children at Feversham had been child psychiatric in-patients, and the school used six referring psychiatrists who each spent a few hours a month at the school. But the school wished to avoid children being 'labelled' maladjusted, and becoming institutionalized, by promoting continuous family contact, an integrated

⁸¹ MIND, *MIND Evidence to the Select Committee on Expenditure Examining the Working of the Children and Young Persons Act 1969*, 18th February 1975, p8.

⁸² MIND, *MIND's Comments on the Court Report on the Child Health Services: The Child Psychiatric Services*, p1.

⁸³ MIND, *MIND Evidence to the Select Committee on Expenditure Examining the Working of the Children and Young Persons Act 1969*, p7-8.

⁸⁴ MIND, *MIND's Comments on the Court Report on the Child Health Services: The Child Psychiatric Services*, p4.

casework service with the family, and ongoing review of a child's length of stay with the family and all agencies involved.⁸⁵ Family therapy was also employed.⁸⁶ These approaches had been advocated and pioneered by mental hygienists through the 1950's and 60's. In 1980 Feversham extended these approaches by opening up case conferences on children's progress to parents. This, it was noted, had proved a 'remarkably successful if somewhat humbling experience for the professionals.'⁸⁷

Feversham also continued principles of open discussion and 'democracy' that had been a cornerstone of David Will's work at NAMH's Reynolds House, and indeed had been advocated by NAMH for the 'treatment' of maladjusted children in general during the 1950's. The school attempted to avoid 'a fixed set of rules intended to govern behaviour' on the grounds that the 'children's need to live out their problems' should be recognized. Staff attempted to employ methods of managing the children that retained the 'permissive and child centred ethos of the therapeutic community'. School rules and sanctions were mostly derived from the twice-weekly gathering of the whole community.

MIND's transformation of its Fairhaven hostel in 1975 was conceived in more radical terms. As we have already seen, Fairhaven had opened in 1957 as a pioneer hostel for adolescents categorized as Educationally Sub-Normal.⁸⁸ The hostel had been headed by a warden and a housemother and was intended to provide for the care, training and treatment of boys between 15 and 17 years. In 1975 Mind revolutionized the Hostel in an attempt to develop new approaches to residential work with young people. But,

⁸⁵ Roger Stansfield, 'A Special Kind of School', *Mindout* No.23 July/August 1977, p6-7; MIND, *Annual Report 1977-1978*, p12.

⁸⁶ MIND, *Annual Report 1978-1979*, p16.

⁸⁷ MIND, *Annual Report 1979-1980*, p16.

⁸⁸ See chapter five, p195.

in fact, what is most significant about Mind's new approach is that, despite its self-professed originality, it recapitulated many central themes in care and therapy promoted by NAMH since the Second World War.

A central principle of the new experiment at Fairhaven was the belief that the condition of patients in mental hospitals could be significantly attributed to the institution and its relationships, rather than to the symptoms of a disease process inside an isolated individual. MIND's social work adviser on the project considered, both the young people resident under the old regime, and those accepted from mental hospitals and other institutions under the new regime, to have become completely dependent on the institution for 'any sense of their own identity'. He believed them 'socially crippled by well intentioned but ill-considered care.'⁸⁹ This was to be reversed under the new ethos. This would institute a decentralized structure to the Home, and to provide an enabling environment in which residents would be helped to cope with life in the community. This was to be an experimental and demonstration project, applying and testing methods of organization that were empowering and non-institutional.⁹⁰

However, as we have seen, Fairhaven had, in fact, originally opened in 1958 with the central aim of combating institutionalism. The adolescents in its care were understood to have been denied healthy expression of their emotions and starved of affection. It was therefore accepted that they were unable to develop adequate relationships with either their peers or older people. NAMH argued that 'traditional' schools appeared to create institutionalized children. As a result emotional

⁸⁹ Laurie Taylor, Ron Lacey and Denis Bracken, *In Whose Best Interests?*, p58-59.

⁹⁰ Eliot Stern, *The Fairhaven Hostel*, p3.

disturbances were likely to develop unnoticed. One consequence was that, at the old Fairhaven, children who displayed 'attention seeking behaviour' were less likely to have this seen as an innate trait of their condition. Rather, they were understood to be exhibiting the consequences of poor and distorted relationships earlier in their lives. This emphasized the heightened sensitivity of the adolescents and their need for sympathetic and nurturing relationships. The 'sensitivity' of staff, therefore became part of the therapeutic problematic. Staff were to be observed in terms of their own attitudes and conduct towards the residents. The old Fairhaven was a beneficiary and contributor to an ongoing transformation in how people considered 'mentally sub-normal' were conceived and treated. Its approach represented part of the re-framing of mental sub-normality, from something innate and, at best malleable, to a condition held to be much more influenced by past, and increasingly, present emotional relationships. The perceived inadequacies of IQ testing were part of this process as we have seen. IQ, had increasingly become understood as only one component of Educational Sub-Normality.

The Policy Outline for the new Fairhaven in fact continued and developed much of this ethos. It maintained that institutionalization contributed to the infantilization of residents by making them dependent upon external controls as well as fostering conformity to institutional norms. Personal development and opportunities for informal shared learning were consequently inhibited.⁹¹

One particular feature of the new Fairhaven was a sustained attempt to reduce the hierarchical nature of relationships believed to be a detrimental feature of

⁹¹ 'Fairhaven Assisted Community Home Policy Outline For Future Development', (1975) p2-5.

conventional institutions. As we have seen this was a general tendency prompted by mental hygienists attention to mental health as principally an issue of dynamic emotional relationships. Therapeutic communities, in particular, had attempted to organize relations around this ethos. Similarly to these, the Fairhaven project's commitment to a 'participative and open community' was an integral aspect of therapy.⁹² The Project Director and staff at Fairhaven appear to have particularly valued this egalitarian, 'democratic' ethos. For instance, it was decided not to appoint a Deputy Project Director. Instead the salary was to be used, both to employ more staff, and reduce the differentials between the Director and staff to compensate for wider delegation of responsibilities.⁹³

One area of change, between the old and new Fairhaven, was that it was believed, under the new regime, that rearranging the physical space and facilities of Fairhaven would combat institutionalization. The centralized kitchen, communal dining room, games and television rooms were all removed. Instead the house was converted into four flats, the largest shared by six people and the smallest by three.⁹⁴ Each resident was provided with keys to their own bedrooms, and each flat contained a shared kitchen, bathroom and living room. Residents were now expected to cook their own meals with assistance when necessary, as well as shopping for food and cleaning their own rooms. However, some of these changes were either hindered by the rambling structure of the house or informally reinstated because residents resisted them.

The new project was based, in part on a perception of the old Fairhaven as institutional in character, embodying a patronizing benevolent paternalism. And,

⁹² 'Fairhaven Assisted Community Home Policy Outline For Future Development', (1975) p4 and 5.

⁹³ Eliot Stern, *The Fairhaven Hostel*, p61.

⁹⁴ 'Give a Man a Fish ...', *Mind Out* No.18 (1976), 12-13, p12.

despite a theoretical embracement of sensitivity to the emotional environment, these had, indeed, been apparent at the old Fairhaven: The virtues of silence, cleanliness and order had been emphasized. Collections had been made for 'the boys' at Christmas time. A bus called every morning to collect those residents who were employed at a local laundry. All these things appeared, to those promoting what they saw as a new ethos, as patronizing aspects of a benevolent paternalism. Many of the staff at the new Fairhaven considered the laundry to be an institutionalized extension of the Hostel. Some of the residents expressed their unhappiness at working there. Nevertheless, the new project was itself beset by a series of crises and criticisms. An interim-report by the Tavistock research team criticized the project's apparent inability, in many areas, to move beyond negative, rather than positive, statements of policy. Discussions and concepts were criticized for centering on what was trying to be avoided. Thus, for instance, admissions procedure sought to avoid 'labelling' and 'stigmatization', whilst discussion around medical and psychological expertise centered on a reduction in consultant power.⁹⁵ On the other hand, the report praised other areas, such as sexuality and access to information where policy was more positively expressed. In addition however, the project ran into problems determining what, in fact, was an 'institutionalizing' environment. Did the frequent staff changes, or resident admissions have an effect on residents such that it constituted a form of institutionalization? How did wider structural influences, such as Fairhaven's uneasy position between its Management Committee, Mind's head office, and local authority demands, create institutionalizing effects? These, and other concerns, were all hotly debated. Fairhaven also encountered similar problems with its attempts to provide aftercare. At first the new Fairhaven continued to use some lodging houses that had

⁹⁵ Eliot Stern, *The Fairhaven Hostel: An Interim Research Report on a MIND/NAMH Residential Project for Young People* (London: Tavistock Institute, March 1978) p39.

provided accommodation for leavers under the old regime. However, it was found that many could be 'unpleasant, dirty and demeaning' and were often run by people with typically institutional attitudes.⁹⁶ For a former resident of Fairhaven, aspects of institutional life could be reproduced creating 'isolating, privatized, fragmented and meaningless' existence. As a consequence Fairhaven after-care policy shifted to attempting to provide shared flats and houses.⁹⁷ This questioning of how institutionalization was constituted, was perfectly in keeping, of course, with the framing of mental disorders in terms of dynamic emotional relationships.

I turn now to the area where people had been most bluntly affected by mental hygienist's neo-moral therapy; what once had been called mental deficiency and now was termed mental handicap.

Mental handicap.

Introduction.

Social and personal relationships are essential to the human condition. The bonds of friendship and love we form with other people enrich the quality of life we enjoy, and this is as true for the graduate of the special school as of the university.⁹⁸

⁹⁶ Eliot Stern, *The Fairhaven Hostel*, p9-11.

⁹⁷ Eliot Stern, *The Fairhaven Hostel*, p10.

⁹⁸ Ann and Michael Craft, 'Personal Relationships and Partnerships for the mentally handicapped' in, Michael Craft, *Tredgold's Mental Retardation* (12th Edition) (London: Bailliere and Tindall, 1979, 354-371, p354.

Nikolas Rose's attack on MIND's rights strategy completely ignored the latter's engagement with the experiences of people termed mentally handicapped (previously, mentally deficient). But, as we have seen, by the time MIND began to adopt a rights approach, people categorized as mentally handicapped were already, in principle, established on the discourse of emotionality. This provided the arena in which MIND campaigned for similar rights.

From Institutionalization to Integration: The Basis of Rights for People Termed Mentally Handicapped.

MIND's campaigning for people termed mentally handicapped continued to advocate the kinds of approaches to residential provision proposed by Jack Tizard at Brooklands, along with his colleagues Norma Raynes and Roy King, and put into practice with Albert Kushlick's work at Wessex. As I have discussed, these approaches essentially brought the principles of care promoted by mental hygienists, and adopted by the Curtis Committee, to residential care for people termed mentally handicapped. In so doing they continued the deployment of the discourse of emotionality that mental hygienists had promoted. The repercussions of a problematic that placed emotional relations as the central point of understanding, and confronting, mental disorders also continued to be played out.

The deliberations of the policy working group, set up by the government in response to the Ely enquiry, were incorporated into a white paper *Better Services for the Mentally Handicapped* published in 1971.⁹⁹ This assessed present service provision and set out targets for hospital and community services over the next twenty years. It

⁹⁹ D.H.S.S., *Better Services for the Mentally Handicapped* (London: HMSO, 1971) Cmnd.4683.

officially accepted and promoted the concept of 'family style' residential provision for mentally handicapped people. The white paper placed great emphasis on the need for residential provision to be domestic and homelike. Government policy now aimed for a 'family atmosphere' where people could live and develop as a small group.¹⁰⁰ When provision was needed as an alternative to a person's own home it was to be as 'homely as possible', and 'provide sympathetic and constant human relationships.'¹⁰¹ However, some medical professionals were intent on retaining the hospital as a specialist community whilst still applying the principles of family style care.¹⁰² In consequence the white paper sat firmly on the fence over whether provision should be hospital or community based. Hospital population was to be reduced considerably but hospitals were not intended to be emptied and closed.

In 1974 MIND released a document criticizing the slow development of community provision by local authorities. It asserted that, in its view, there was a mandatory obligation upon local authorities to provide care and after-care for people with mental disorders. The 1946 National Health Service Act had only provided local authorities with the discretionary power to provide this care. MIND argued that both the 1959 Mental Health Act and the 1968 Health Services and Public Health Act had reinforced this power to the extent that it was now mandatory. On the basis of this view MIND signaled its decision to pursue test cases to firmly establish the legal right to community care.¹⁰³

¹⁰⁰ D.H.S.S., *Better Services for the Mentally Handicapped*, paras 80 and 90.

¹⁰¹ D.H.S.S., *Better Services for the Mentally Handicapped*, paras 161-6, 168, 184.

¹⁰² 'Anatomy of an Achievement in a Mental Subnormality Hospital', and, Anne L. Amsden, 'Anatomy of an Achievement: What the Nurses Did – and Are Doing', *Nursing Times* 67 No.22, 3rd June 1971 670-673.

¹⁰³ MIND, Report No.13, *Co-ordination or Chaos?: The Run-down of the Psychiatric Hospitals* (London: MIND, May 1974), p20-21 and 26. MIND cited a passage from Circular 22/59 of 7th August 1959 which read, '... the Minister ... hereby directs ... that ... arrangements shall be made by every

MIND's advocacy of community care promoted the development of hostels for mentally handicapped people on the lines developed by Albert Kushlick in Wessex. This showed, MIND emphasized, that care and integration within the community could be provided for all including the most severely mentally handicapped people.¹⁰⁴ MIND's promotion of this work re-asserted the mental hygiene problematic that placed mental health and development at the centre of dynamic emotional relationships. And, as I have shown, the work was itself an elaboration of the emotional-relational problematic expressed across significant sites to which mental hygiene addressed itself from the Second World War; sites such as residential care for 'normal' and 'maladjusted' children, therapeutic community work, and the Social After-Care Service. Mentally handicapped people's emotional experience and expression was now firmly located on the discourse of emotionality from which they had once been excluded. The effects of institutional provision, such as, 'block treatment', 'social distance', and 'depersonalization', accompanied as they were, with a lack of continuity of care and hierarchical authority, continued to be stressed as detrimental to mental health and development.¹⁰⁵ MIND linked Albert Kushlick's community experiments with the earlier work of those such as Jack Tizard, Erving Goffman, and Russell Barton, who had described these types of effects of institutionalization.¹⁰⁶ When Albert Kushlick's research unit came under funding threat MIND publicly defended the importance of its work.¹⁰⁷

local health authority for the purpose of the prevention of mental disorder and ... the care of persons suffering from mental disorder and the after care of such persons'. (p21).

¹⁰⁴ MIND, Report No.13, *Co-ordination or Chaos?: The Run-down of the Psychiatric Hospitals* (London: MIND, May 1974), p12-15.

¹⁰⁵ Lindsay Knight, 'Better Services in Wessex?', *Mindout* No.28 May/June, 1978 6-8.

¹⁰⁶ Alison Wertheimer, 'Researching into Mental Handicap', *Mindout* No.40 May/June 1980 16-18, p17.

¹⁰⁷ 'Wessex Research Unit Threatened with Closure', *Mindout* No.45 January 1981, p4; 'Threat to Wessex Research Unit Postponed', *Mindout* No.46 February 1981, p4.

In 1975 the government set up the Jay Committee to assess the staffing of mental handicap residential care in, both the National Health Service, and local authorities.¹⁰⁸

The report that resulted in 1979 was an explicit attempt to definitively establish that children diagnosed mentally handicapped and who needed residential care, should receive the same kind of 'family substitute' care as had formed the principles of residential care for other children ever since the Curtis Committee and the 1948 Act that followed it. Thus it represented the forceful assertion that mentally handicapped children be placed on the same discourse of emotionality as other children. In fact, the Jay report went further and stretched the Curtis Committee recommendations to encompass residential care for mentally handicapped adults as well. It explicitly promoted the research and practice of Jack Tizard and Albert Kushlick. MIND hailed the Jay Report as 'the most important contribution to thinking in the residential care of the mentally handicapped for many years.'¹⁰⁹ It cited Maureen Oswin's recent study of the care of children living in long-stay hospitals as support for its agreement with Jay. This had shown that hospital provision was detrimental to mentally handicapped children's health and well-being and that much difficult behaviour was a consequence of the poverty of emotional relations in the institution.¹¹⁰ MIND viewed the key 'homemaking principle' of the Jay report as central to building 'comprehensive community facilities' away from mental handicap hospital care.¹¹¹ The Jay Report forthrightly propounded the principles of continuity of care with the construction of emotional relationships as 'normal' and 'homelike' as possible, that mental hygienists

¹⁰⁸ Report of the Committee of enquiry into Mental Handicap Nursing and Care (Jay Committee) HMSO 1979 Cmnd 7468.

¹⁰⁹ MIND, *MIND's Response to Jay* c.1979, p20. Though it noted that, in the face of government expenditure cuts, the omens for its full implementation were not good.

¹¹⁰ Maureen Oswin, *Children Living in Long-Stay Hospitals*

¹¹¹ MIND, *MIND's Response to Jay*, p7.

had propounded for 'normal' children in the 1940's. It also extended the emphasis on integration and access to the community that had been promoted as essential to healthy emotional experience and development. Freedom and choice were also emphasized. From the 1940's the emotional-relational problematic employed by mental hygienist's in their theorizing on residential child care, therapeutic communities, and the Social After-Care Service, had reconfigured notions of freedom and choice. They became central aspects of emotional expression within a relational milieu that were, both a sign of mental well-being, and part of the means to attain it. The Jay report reiterated this and furthered its official acceptance with regard to people termed mentally handicapped. Mentally handicapped people, it maintained, had the right to be treated as individuals, make choices and take the risks inherent in living a full rich life.¹¹² As a constituent of these proposals for social individuality and integration the Jay Report also deployed and developed the common mental hygienic theme of multi-disciplinary teamwork. It proposed a Community Mental Handicap Team.

Jay also expressed, however, some of the ramifications of the emotional-relational problematic that had gradually undermined mental hygienists claimed expertise and the histories much of this was based upon. Though living with the same diagnostic label, mentally handicapped people were not to be treated simply as a homogenous group. There was to be less importance placed on labeling and grading.¹¹³ This was reflected in a reorientation of staff training and roles, from a medical model to a social and developmental model. The history of arrested development and its conflation

¹¹² Report of the Committee of Enquiry into Mental Handicap Nursing and Care (Jay Committee). P10-11.

¹¹³ This had also been expressed in the Warnock Report on mentally handicapped children's education. See, Report of the Committee of Enquiry into the Education of Handicapped Children and Young People (Warnock report) (HMSO, 1978).

with health and 'efficient citizenship' was subverted. MIND strongly supported all these proposals. In a clear, and ironic, expression of this reversal MIND maintained that training of care staff should be modeled on the same principles as that of modern methods for teaching mentally handicapped people themselves.¹¹⁴ People termed mentally handicapped were no longer a race apart with primitive requirements needing accordingly unsophisticated training and care. The dynamics of emotional experience in learning and living were to be central to both staff and client's instruction. Emotional sensitivity was crucially important. Where, until recently, only mentally handicapped people were deemed to need training in socialization so that they could 'give' as well as 'take' in human relationships, now this one-way reason was reflected back upon the staff.¹¹⁵ Carers were to be trained in appreciating the inter-personal and emotionally sensitive dynamics of relationships with clients and reflect on their own place in these dynamics.¹¹⁶ MIND, along with the newly formed Campaign for the Mentally Handicapped (CMH), also publicized evidence which they claimed showed that the traditional homogenization of mentally handicapped people as a social problem group had disguised, both these people's similarity to 'normal' people, *and* their distinctive individuality.¹¹⁷ A CMH report, publicized in *Mindout*, maintained that the medical model of care was increasingly considered to be obsolete. It reiterated that community care should be based upon a 'democratic' multi-

¹¹⁴ MIND, *MIND's Response to Jay*, p11.

¹¹⁵ H.C. Gunzburg, *Junior Training Centres: An Outline of the Principles and Practices of Social Education and Training of the Mentally Subnormal Child*. (London: NAMH, 1963) [reprinted 1966], p10.

¹¹⁶ MIND, *The Mental Handicap Component in Social Work Training: A Handbook for Tutors and Training Officers: Report of a MIND Working Party* (London: MIND, May 1977), p18 (and throughout); Ann Shearer, 'Institutions don't have to be bad', *Mindout* No.50 June 1981 11-13, p13; Joanna Ryan and Frank Thomas, *The Politics of Mental Handicap* (Harmondsworth; Penguin, 1980), p144-147.

¹¹⁷ See, for instance, Ann Shearer, *Disability: Whose Handicap?* (London: Blackwell, 1981) and review in *Mindout* No.54 October 1981, p22.

disciplinary model of educational and social models of care.¹¹⁸ Care for mentally handicapped people, it was maintained, entailed a 'hard critical look at the roles of powerful professionals.'¹¹⁹

Institutional Provision is Emotionally Disabling.

The application of the emotional-relational problematic in the early 1950's, by some mental hygienists and by the NCCL, had shown that institutional treatment was significantly emotionally disabling. In fact it appeared to promote many of the behavioural, emotional and sexual 'problems' it claimed to be preventing. These deductions continued to be expressed and developed. At the same time, the linkage of freedom and choice with emotional relationships as the locus of mental health and personhood – so clearly made during the 1940's - became increasingly distinct regarding mental handicap. MIND drew attention to the historical neglect of mentally handicapped people's emotional and sexual fulfillment. Greater recognition of this had been promoted by MIND in a 1972 pamphlet authored by Ann Shearer, the former Guardian journalist, and founding member of the CMH.¹²⁰ This maintained that it was 'still widely believed that mentally handicapped people are uncontrolled and perverted in their sexual appetites.' It went on to note that policies of segregation had built on and fed this myth. The resulting institutional system had separated these people from 'normal emotional patterns of life', promoted the myth that their sexual emotions and feelings constituted a danger to society, and actually helped to fabricate

¹¹⁸ CMH, *Enquiry Paper No.8* (1979) described by Alan Tyne, the research officer for the CMH, in, 'Who's consulted?', *Mindout* No.32 January/February 1979, p8.

¹¹⁹ Alan Tyne, 'Who's Consulted?' *Mindout* No.32 January/February 1979, p8.

¹²⁰ MIND, *A Right to Love?* (MIND, 1972) [Reprinted in *MIND and Mental Health* Summer 1972 14-17]

the 'odd behaviour' that such stereotypes depicted. The leaflet declared, '...it is our 'treatment' of their needs that has been perverted – not the needs themselves.'¹²¹

Research publicized by MIND showed that the denial of relatively normal relationships in hospitals prevented 'normal' outlets for emotional expression.¹²² The structural design of mental handicap hospitals was considered to militate against opportunities for, both social and sexual integration, *and* against privacy.¹²³ MIND was prominent in setting up group homes as a means to provide community care and repair the damage of institutionalization. It was now stressed that men and women confined in institutions for many years of their lives suffered from having had to live in an 'emotional vacuum'.¹²⁴ Group homes, as I have discussed, continued the emphasis on reducing hierarchy and authoritarian relationships between staff and residents. MIND maintained that, in fact, living together without direct supervision had resulted in improved emotional relationships, with one consequence being that residents displayed an improvement in communication skills. A further result had been a boost to self-confidence and greater willingness to stand up to what residents sometimes experienced as unnecessary authority. But MIND noted that some researchers had shown that this had caused hostility from those who still expected mentally handicapped people to be 'docile and accepting'.¹²⁵ MIND reasserted what had been a central contention of therapeutic communities; that, 'the label "difficult"

¹²¹ MIND, *A Right to Love?*, p15.

¹²² MIND, *Getting Together: Sexual and Social Expression for Mentally Handicapped People* (London: MIND, 1982), p9; Janet Mattinson, *Marriage and Mental Handicap* (2nd edition) (London: Tavistock Institute of Human Relations, 1975); Ann and Michael Craft, *Sex and the Mentally Handicapped* (London: Routledge and Kegan Paul, 1978); Ann and Michael Craft, *Handicapped Married Couples* (London: Routledge and Kegan Paul, 1979); 'Sex Education for the Mentally Handicapped', *Mindout* No.35 July/August 1979, p7.

¹²³ MIND, *Getting Together*, p17.

¹²⁴ 'We Work for Mentally Handicapped People Too', *MIND In Action '81* (Publicity newsletter), p3. (MIND archive).

¹²⁵ MIND, *Getting Together*, p8.

applied to mentally handicapped people may be a reflection of staff attitudes – and it is time that this fact was recognised.¹²⁶

Ann Shearer, of the CMH, which worked closely with MIND¹²⁷, criticized what she argued was an outmoded hierarchical system through which insensitivity at each level rebounded painfully on the one below, with mentally handicapped people, at the lowest level, affected the most. She complained that the ideal of the therapeutic community, in which everyone – staff or clients – was equally important to the whole – was still unrealized. She attributed much of the reason for this to the ethic of professionalism. What was required, she maintained, was shared and egalitarian relationships that enriched the lives of clients and staff together. The entire impetus of the professional ethic, on the other hand, had been the creation of distance between carer and client. Weren't we being too pompous about professional qualifications, she asked?¹²⁸

Developmental History Re-Asserted?

I have argued in this thesis that when mental hygiene altered its engagement with emotionality to conceptualizing it in terms of dynamic relationships, it paradoxically ruptured the accounts of progressive human and social development on which it founded its authority. But histories of development were not simply discarded. The history of 'arrested' development may have become subverted, but the discourse of

¹²⁶ MIND, *Getting Together*, p8.

¹²⁷ MIND, *The State of MIND* (Pamphlet), 1.

¹²⁸ Reported in, Mary Manning, 'Do Staff Really Need Qualifications?', *Community Care* 1st October 1975, p7. Ann Shearer described her experience of L'Arche communities as coming closest to the residential ideal. The first of these had been set up by a French Canadian Jean Vanier in 1964. By 1979 there was an international network of fifty branches.

emotionality retained a developmental component that was linked to the attainment of integrated citizenship and 'normal' lifestyles for mentally handicapped people. There remained an antagonism between valuing people's emotional relationships as valuable sources of knowledge in their own right, and considering that they should be developed and shaped in order that social integration might be facilitated. MIND and the CMH's promotion of the principles of 'normalization' exemplify this.

Normalization had developed as a theory around a cluster of ideas and approaches employed in work with mentally handicapped people in 1960's Scandinavia.¹²⁹ In Denmark, N. E. Bank Mikkelsen had defined the approach as, 'to let the mentally subnormal obtain an existence as close to the normal as possible.'¹³⁰ The Swedish theorist Bengt Nirje developed similar theories, and emphasized the inter-personal and institutional factors that combined with innate cognitive handicaps in exacerbating such people's ability to cope with normal aspects of living.¹³¹ The family style care that represented a part of this approach was, in fact, similar to that promoted in the 1940's for 'normal' and 'maladjusted' children. The Jay committee's promotion of family style residential community care, therefore, was considered to be an element of normalization principles. But normalization was also promoted in Britain on the basis of the American psychologist Wolf Wolfensberger's influential development of the approach.¹³² In part, his work, built on the kinds of analyses of emotional relations that I have analysed. In part also, it built on theories of deviancy and 'labeling' then prevalent in sociology. This version of normalization prioritized the

¹²⁹ Bengt Nirje, 'The Normalization Principle – Implications and Comments' in, H.C. Gunzburg, (ed) *Advances in the Care of the Mentally Handicapped* (London: British Society for the Study of Mental Subnormality, 1973) 29-38, p29.

¹³⁰ Bengt Nirje, 'The Normalization Principle', p29.

¹³¹ Bengt Nirje, 'The Normalization Principle', p31.

¹³² Wolf Wolfensberger *et al*, *The Principle of Normalization in Human Services* (Toronto: National Institute of Mental Retardation, 1972).

goal of raising the civil and social status of mentally handicapped people and facilitating their social integration. This made it of obvious use for MIND's similarly directed rights strategy. Normalization was promoted and developed in Britain principally by the CMH, and the Kings Fund, but also, in part, by MIND. The latter observed that:

In the past mentally handicapped people have often been treated as second class citizens and even now are still denied opportunities for personal development regarded as fundamental and essential rights by the rest of the community. They are an extremely vulnerable minority group usually unable to speak for themselves adequately and defend their own rights.¹³³

There is a tension here. Are people termed mentally handicapped to be assisted in asserting a right to having their own experiences and opinions valued? Or is their right to 'personal development' to be primary? Wolfensberger's approach sought to enhance the social *role* of the person. He wrote:

It is important to distinguish between the valorisation of the role of the person, and valuing (or valorisation) of the person him/herself. When we speak of valuing the person, we step at least partially outside a theoretical framework that is profoundly anchored to empiricism and into the realm of super empirical value systems.¹³⁴

¹³³ MIND, *MIND's Response to Jay*, p5-6.

¹³⁴ Cited in, Michael Bayley, 'Normalisation or 'Social Role Valorisation': An Adequate Philosophy?', in Steve Baldwin and John Hattersley (eds) *Mental Handicap: Social Science Perspectives* (London: Routledge, 1991) 87-99, p88.

In fact, he explicitly argued that 'the right not to be segregated and institutionalised ... is really a bigger issue than the restriction of individual choice.'¹³⁵ But, given this view; what should staff do if a 'devalued person' chose what was seen as a 'devalued' option? Wolfensberger suggested that,

First, one pursues the line of persuasion, pedagogy, modeling and other forms of culturally normative social influences to steer a person toward a course of action one desires. Second, one imposes coercion only where one would do so legally in the larger societal context, ie where one would do so with other (valued) citizens of the same age. Third, one chooses the least restrictive alternative if one does coerce'¹³⁶

In fact, 'non-coercive change', for Wolfensberger, could include 'systematic and long term reinforcement for emitting the desired responses.'¹³⁷ Thus it appears here that choice and the expression of emotional experience are to be circumscribed in the client's 'own best interests'.

Such apparent contradictions were contested at the time. For instance, Joanna Ryan (who had until recently been a research officer for MIND) co-authored a book on mental handicap in which she pointed out that the spirit of reform in mental handicap had continually been tied to the promise that mentally handicapped people could be improved; and that the path to greater acceptance lay in some kind of normality.¹³⁸

¹³⁵ Cited in, Eric Emerson, 'What is Normalisation?', in Hilary Brown and Helen Smith (eds) *Normalisation: A Reader for the Nineties* (London: Routledge, 1992) 1-18, p12.

¹³⁶ Cited in, Eric Emerson, 'What is Normalisation?', p12.

¹³⁷ Cited in, Eric Emerson, 'What is Normalisation?', p12.

¹³⁸ Joanna Ryan with Frank Thomas, *The Politics of Mental Handicap*, Harmondsworth; Penguin, 1980), p122.

This statement highlights the continuities evident between approaches promoted by mental hygienists and aspects of normalization theory. In 1980, *Mindout* published an extract from this book. This excerpt charged that normalization and the 'right to normality', though promoting integration and combating descrimination, could not be accepted uncritically. Joanna Ryan pointed out that one of Bengt Nirje's descriptions of normalization was that it involved a 'better adjustment to society'. But she remarked:

'... mentally handicapped people may wish to question and reject some of the more exploitative and oppressive standards of our society, just as many non-handicapped people do. Many people choose to live in various unconventional ways, for example in communes in the country, or shared households in the city, to reject certain standards of conventional dress and typical sex-role behaviour, and mentally handicapped people may wish to do so too.'¹³⁹

This article drew a response from Alison Wertheimer of the CMH in a later issue of *Mindout*. She maintained that the CMH advocated normalization because it was concerned with promoting people's dignity and choice, and 'not with coercing them to do things that they might not want to do or that might be against their interests.'¹⁴⁰ But she admitted that the interpretation of normalization by service providers could be helpful or unhelpful to these aims.

¹³⁹ Joanna Ryan with Frank Thomas, 'Getting back to 'normal'', *Mindout* No.42 October 1980 17-20, p20.

¹⁴⁰ Alison Wertheimer, letter, *Mindout* No.44 December 1980, p10.

There was substance to both sides of the argument. The psychologist H.C. Gunzburg, who had worked with the NAMH during the 1950's and '60's, continued to promote the hospital as a 'normalizing environment' in which people's practical and relational skills could be adjusted so that they were more acceptable outside. The sociologist Peter Townsend described this as 'the fake "normalization" solution' dismissing it as a continuation of the myth of rehabilitation through institutional treatment.¹⁴¹

Nevertheless, such approaches remained prominent and, in addition, could continue to take an uncritical view of the societal norms to which people were supposed to be adjusted. For example, one psychiatrist who deployed normalization approaches at a mental handicap hospital explained that: 'Residents are encouraged to undertake the roles they would have in a normal family, the women doing the domestic chores and assisting in the day-to-day care of the children and the men going out to work.'¹⁴²

These approaches also tended to reduce normalization back to determining and acting upon, 'those who can be normalized', rather than emphasizing access to a 'normal' environment in which integration could take place. Indeed, some professionals cautioned against 'loose talk of "normalisation" across the entire range of mental retardation', stressing that only the most independent could be expected to be integrated into the community. The CMH, however, deprecated such views as limited and pessimistic.¹⁴³

¹⁴¹ Peter Townsend, 'The Political Sociology of Mental Handicap: A Case-Study of Policy Failure' in, David M. Boswell and Janet M. Wingrove, *The Handicapped Person in the Community* (London: Tavistock and OUP, 1974) 432-440, p436.

¹⁴² K. Day, 'Care of the Mentally Handicapped', in A. Baker (ed) *Comprehensive Psychiatric Care* (London: Blackwell Scientific Publications, 1976), cited in Joanna Ryan with Frank Thomas, *The Politics of Mental Handicap*, p131.

¹⁴³ See, Alan Tyne (Research Officer for the CMH), review of, D.J. Eden, 'Mental Handicap: An Introduction', *Mindout* No.16 May/June 1976, p21.

Fighting Hierarchies of Mind: Emotional Relationships Matter.

Perhaps as a means to combat this the Campaign for the Mentally Handicapped organized the first conference for mentally handicapped people in 1972.¹⁴⁴ The introduction to the report of this conference noted that, whilst many delegates had received 'half-joking admonitions from staff about what they were going to say', their comments about services and staff were 'often painfully perceptive', showing 'how much we could learn from them if we listened more.'¹⁴⁵ Originally mental hygiene had de-legitimized the emotional experience of people then classified as mentally deficient. On the basis of a history that purported to show their deviation from social and evolutionary progress, their emotional experience and expression had largely been relegated to an innate and 'primitive' phenomena that required order and control. The shift to a problematic centered on emotional relationships had ruptured this history. It undermined the homogenization of mental deficiency as a 'social problem' and disrupted the importance of 'grading' and categorization within this group. At the same time it had increasingly suggested that 'institutionalization' represented, not a treatment, but a disorder in itself – and one that created many of the behaviours that it claimed to control and ameliorate. Echoing criticisms of care made in the 1950's, the CMH noted of the 1972 conference that, the wishes expressed by delegates were not unreasonable. Indeed they were so modest that they begged the question why this was so.¹⁴⁶ The conference was organized around three periods of group discussion. In effect it resurrected the open style group discussions experimented with by Jack

¹⁴⁴ CMH, *Our Life: A Conference Report* (London: CMH, August 1972).

¹⁴⁵ CMH, *Our Life*, p1.

¹⁴⁶ CMH, *Our Life*, p1.

Tizard and Neil O'Connor at the Fountain hospital in the early 1950's. But the conference invoked no justificatory claim that it improved social skills or IQ.¹⁴⁷

Perhaps what is most interesting about the opinions voiced at this conference is the extent to which they express many of the principles of care developed by mental hygienists for 'normal' and 'maladjusted' children without homes. Similarly, they express many of the guiding approaches of the therapeutic community approach.

Some impression of the continuing extent of social distance between staff and residents in some hospitals is evident even in delegates comments about arrangements for people to move to community care provisions. In the early 1950's the NCCL had declared that 'there is never a hearing for a mental defective' and that in contrast to mental defectives themselves it was often doctors and administrators who refused to listen or give a straight answer. Delegates at the 1972 conference expressed similar views. One had been asked by a doctor if she wanted to live in a hostel. On replying that she would the doctor had said that he would see what he could do. A year later she had still heard nothing from him. She remarked: 'It's like talking to a brick wall.' Another delegate relayed how his hospital sent people to live in hostels without the chance to visit and decide if it suited them beforehand, and with only three or four days notice. Another complained that at her hospital people were sometimes taken directly from the workroom to pack their things and leave.¹⁴⁸ Others similarly complained that they were not told of changes that would have an important impact on their lives until the last minute, or at times, not at all.¹⁴⁹

¹⁴⁷ Though one delegate in fact remarked that she thought that everyone felt better able to communicate by the end of the conference: CMH, *Our Life*, p26.

¹⁴⁸ CMH, *Our Life*, p8.

¹⁴⁹ CMH, *Our Life*, p16.

Only two delegates thought they would like to live completely alone. Most wanted to live in a small house with a few friends. They thought that they would need some help to cope. The delegates wanted the staff to be more like 'housekeepers' or 'guides' than the roles they presently adopted.¹⁵⁰ Some expressed the desire to share meal times with staff. Views were, variously, that; it would help to make it more like a family, it would be more company, and it might make it easier to talk to staff. Others, however, emphasized that they continued to find it difficult to contemplate talking to staff. One had asked whether there could be joint meetings between staff and residents but had been told that meetings were only for staff. Some delegates reported that they had to call staff by the titles 'nurse' or 'sister'. One felt that it was very important for the staff not to wear uniforms because, 'it means they're not part of the hospital, you see.'¹⁵¹ Another remarked: 'I call them 'sir' for a joke, sometimes, and salute, but you have to be careful. It's like the army, you see – the staff are in charge, that's why they wear uniform'.¹⁵²

Emotional relationships mattered; and they were clearly deteriorated by authoritarian, hierarchical, and task oriented care.

¹⁵⁰ CMH, *Our Life*, p9.

¹⁵¹ CMH, *Our Life*, p16.

¹⁵² CMH, *Our Life*, p15.

Chapter Seven: Emotions Suppressed: Nikolas Rose and 'Strong Social Constructionism'.

It is vital to respect the personal wisdom of others. ... In the actual process of communicating all theories are parched bones in the desert.¹

Some of us know what it is like to be learning disabled; others are university researchers who don't know what it is like ... No disrespect to university people but they don't know what it's like to be learning disabled, they don't have the knowledge.²

Introduction.

In the previous chapter I showed that the legal rights approach to mental health pursued by MIND cannot be reduced to an image of the colonization of a voluntary mental hygiene organization by a separate discourse of civil rights. Theories of citizenship and considerations of civil liberties interacted integrally with the project of mental hygiene throughout its history. I centered my argument around Nikolas Rose's contemporary critique of the then prominent legal rights strategy. I wanted to show that many of the characteristics Rose applied to this strategy were inaccurate. However, in theory, it might appear that these revisions could be relatively easily incorporated into Nikolas Rose's primary thesis of which his criticism of rights represents only one aspect. That is, they could be reduced to further elements in the construction of our 'selves'. In this final chapter I want to show that these revisions cannot, in fact, be so easily incorporated. Indeed I aim to show that the strong social constructionist theories of 'the self', of which Nikolas Rose provides one of the most

¹ David Brandon, 'Being Ordinary', *Mindout* No.51 July 1981 12-14, p14.

² D. Docherty, R. Hughes, P. Phillips, D. Corbett, B. Regan, A. Barber, M. Adams, K. Boxall, I. Kaplan, S. Izzidien, 'This is what we think', *Disabilities Studies Quarterly*, (forthcoming) cited in Peter Beresford, *It's Our Lives: A Short History of Knowledge, Distance and Experience* (London: Citizen Press, 2003), p9.

influential and sustained, are flawed. I aim to show that the theory's representation as a radical critique of prevailing understandings of 'the self' is illusory. I argue, that despite its apparently radical credentials, the theory just serves to perform yet another version of one-way reason whereby personal experience can only speak in terms of the definition supplied for it.

I begin by returning to Nikolas Rose's criticisms of the rights strategy in mental health in order to discuss this in terms of his more fundamental thesis.

Rose's criticism of rights

Through the 1970's and 80's a rush of historians and historical sociologists provided radical and revisionist accounts of medicine and the social welfare system. These theorists developed analyses which have since become commonplace conceptual references in historiographical discussion of medicine and social welfare. They included the concepts of social control, medicalization of social problems, professional entrepreneurship, analysis of social movements and the social construction of medical knowledge.³ Nikolas Rose's work, developed in the 1980's must be situated with these contemporary critiques. A central element informing

³ Examples include, David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little Brown, 1971); Andrew Scull, *Museums of Madness: The Social Organization of Madness in 19th Century England* (London: Allen Lane, 1979); Geoffrey Baruch and Andrew Treacher, *Psychiatry Observed* (Routledge and Kegan Paul, 1978); Roger Cooter, 'Phrenology and British Alienists', in Andrew Scull, *Mad-Houses, Mad-Doctors and Madmen* (London: Athlone Press, 1981); David Ingleby (ed) *Critical Psychiatry: The Politics of Mental Health* (Harmondsworth: Penguin, 1981); Stanley Cohen and Andrew Scull (eds), *Social Control and the State: Historical and Comparative Studies* (Oxford: Martin Robertson, 1983); Robert Castel, 'Moral Treatment: Mental Therapy and Social Control in the Nineteenth Century' in, Stanley Cohen and Andrew Scull (eds), *Social Control and the State: Historical and Comparative Studies* (Oxford: Martin Robertson, 1983); Peter Wright and Andrew Treacher, *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (Edinburgh: Edinburgh University Press, 1982).

many of these approaches was the contention that social welfare policies, and particularly the medical concepts which were often employed, entailed a 'taken-for-granted' knowledge that presented medicine and welfare as obviously 'progressive' and un-contentious. As Wright and Treacher put it in their introduction to *The Problem of Medical Knowledge*:

... if science was the accurate reading of Nature's book with eyes undistorted by social interest or cultural prejudice, medicine was the benevolent application of some of what was found there. The history of medicine, in consequence, was frequently expressed in triumphalist terms: as a process of refining; of separating the pure, neutral, scientific essence from everything that had contaminated it.⁴

Until recently, sociologists had, along with doctors, talked of the 'problem' of mental deficiency and the 'problem' of mental illness. Now a central topic for academic analysis became the 'problem' of medical knowledge itself. Some of these accounts in fact acknowledged that part of the impetus for this perspective had come from medical workers themselves; for example in their questioning of the structure of power in hospitals.⁵ Many of these revisionist accounts also sympathized with the radical sociological and anti-psychiatric critiques of medicine and psychiatry developed from the 1960's. Deviancy theory and its radical off-shoot 'labeling theory', for instance, provided a significant amount of the stimulus for this work. But what these previous critiques lacked, it was now claimed, was history. History was to provide the knowledge which would 'open up' the sanctified knowledge of medicine.

⁴ Peter Wright and Andrew Treacher, *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (Edinburgh: Edinburgh University Press, 1982), p4.

⁵ Peter Wright and Andrew Treacher, *The Problem of Medical Knowledge*, p1-2.

For example, the concept of 'social control', as employed by sociologists of the twentieth-century until around the 1960's was, according to Andrew Scull and Stanley Cohen, 'essentially social psychological'.⁶ As such, they claimed, it presented, through its key concepts of 'internalization' and 'socialization', an image of the relationship between individuals and society that was bereft of history. And indeed, it is commonly agreed that, from the latter 1960's, sociologists of deviance rediscovered history and were joined by revisionist social historians who placed notions of reform, humanitarianism and progress under attack.⁷ History, it appeared, was the crucial component lacking from the original notion of social control and of the later sociological critiques – notably 'labelling theory' – that developed around the concept. But, despite the clear divergences of interpretation over, variously; 'epistemology, materialist-versus-idealist versions of history, and the sources of social change', one thing, it seems, remained agreed upon, and that was the un-contentiously 'progressive' role of 'introducing' academic historical knowledge and understanding into these areas.⁸ Thus, it was claimed, the relationships between individuals and society could not be properly understood without the concept of history, and, despite appearances (and some utterances) to the contrary, the bulk of historians and historical sociologists tacitly justified this introduction as, in fact itself, 'progressive'.

Nikolas Rose's social constructionist work has also sought to introduce history to medical knowledge and practice in order to provide a radical critique of psychiatry and psychology. His continuing work takes things a step further however. History has now become the means to show that 'the self' – personal existence and experience –

⁶ Stanley Cohen and Andrew Scull (eds), *Social Control and the State*, p5.

⁷ Stanley Cohen and Andrew Scull (eds), *Social Control and the State: Historical and Comparative Studies*, (Oxford: Martin Robertson, 1983), p3-7.

⁸ Stanley Cohen and Andrew Scull (eds), *Social Control and the State*, p5.

has itself been 'constructed' by the psy discipline's knowledge and practices. It is important to be clear about this distinction. It is not just psychological categories, and practical ways of understanding and dealing with 'the self' that have been constructed. This would merely constitute a tautology. Rather, it is 'the self' itself which has been constructed; actual personal existence and experience. Nikolas Rose's critique of the rights strategy in mental health in fact represents an element of this more fundamental claim.

For Rose, a primary characteristic of the notion of rights is that it is history-less. The 'individual free to choose', as he terms rights bearers, is not 'natural' or universal. Rights are not timeless but have a history that must be investigated. Indeed, he points out that, the presentation of rights as universal serves only to mask what was in fact a historically specific social and political strategy. In his critique Rose makes use of socialist arguments to bolster his position. Socialists, he reminds his readers, have long struggled over the utility of rights as a strategy capable of promoting fundamental social change. This is certainly the case. Indeed, some socialist writers, such as Peter Sedgwick, argued in the 1980's that rights based moves to reform medicine peddled an illusion that liberty and equality could be achieved through focusing on the misuse of particular medical practices rather than challenging the structural aspects of that power.⁹ Others, however, whilst recognizing these contradictions, nevertheless considered rights campaigns to be useful, though limited and pragmatic, strategies of empowerment for minority groups and the working class in general.¹⁰

⁹ Peter Sedgwick, *Psycho Politics* (London: Pluto Press, 1982), p178-9 and 217.

¹⁰ Tom Campbell, *The Left and Rights* (London: Routledge and Kegan Paul, 1983).

Nevertheless, Rose deploys history as the 'objective' means to argue that the same 'transformations of social and intellectual rationality' that gave birth to civil libertarianism also founded psychiatry as a discipline. Citing theorists from Foucault, to Karl Marx, to the contemporary moral philosopher Alasdair MacIntyre, Rose maintains that:

The very same social, political and intellectual forces that inscribed the slogans of the rights of the individual upon their banners in the late eighteenth and early nineteenth centuries also invented all those disciplinary mechanisms for the systematic management of individuals through actions targeted upon the soul.¹¹

We might note here that this historical contention need not imply (as Rose appears to suggest) a functionalist explanation. It does not necessarily follow that since 'the rights of the individual' and 'disciplinary mechanisms for the management of individuals' became manifest amongst, what he calls, the same broad ranging 'social, political and intellectual forces' they therefore have a necessarily functional fit with each other. Foucault does not appear to have taken this view. Despite his genealogical studies which attempted to disrupt prevailing essentialist concepts of 'the self', he himself employed the notion of rights on more than one occasion in his political campaigning.¹²

Rose contrasts his historical evidence with rights arguments in mental health, which he claims, maintained that there was a continuity 'between the involuntary

¹¹ Nikolas Rose, 'Law, rights and psychiatry', in Peter Miller and Nikolas Rose (eds) *The Power of Psychiatry* (Cambridge: Polity Press, 1986) p200-201.

¹² Jon Simons, *Foucault and The Political* (London: Routledge, 1996), p10-11.

confinement of the disturbing eccentric, the quarrelsome alcoholic or the socially disruptive derelict and the burning of witches, the pathologization of homosexuality and the confinement of political deviants in the Gulag Archipelago.¹³ Thus these claims evacuated the concept of rights of its own history. The very notion of rights was thoroughly implicated in the bourgeois market governed by private contracts between atomistic autonomous individuals. Subsequent evidence appears to support some of this. Despite the evident fact that, as one contemporary rights protagonist emphasized, the 'discourse of rights' cannot be reduced to a homogeneous and undifferentiated school of thought,¹⁴ it remains the case that rights based strategies were easily appropriated by the Conservative governments of the 1980's and put to the service of 'consumer choice' in its policies of privatisation and marketisation in the NHS.¹⁵ There is further evidence in the employment of rights notions by medical ethicists operating under the contemporary rubric of 'bioethics'.¹⁶ The historian and medical ethicist David Rothman, for instance, maintained in the early 1990's that bioethics has been so successful in the United States because its defence of the rights of patients transcends political and socio-economic considerations.¹⁷ An explanation that appears to divest both the concepts of rights and medical ethics of any social and historical context.

¹³ Nikolas Rose, 'Law, Rights and Psychiatry', p199. See also Peter Miller, 'Critical Sociologies of Madness' in Peter Miller and Nikolas Rose (eds) *The Power of Psychiatry* (Cambridge: Polity Press, 1986) 12-42, p27. Here Miller links 'critical sociologies' and 'anti-psychiatry' together as asserting the same continuity.

¹⁴ Phil Fennell; 'Law and Psychiatry : The Legal Constitution of the Psychiatric System', *Journal of Law and Society*, Vol 13, no. 1 (1986), 35-65, p58

¹⁵ Roger Cooter, 'The Ethical Body', in Roger Cooter and John Pickstone (eds) *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic Publishers, 2000), 451-485, p464; Anne Rogers and David Pilgrim; *Mental Health Policy in Britain: A Critical Introduction* (London : MacMillan Press Ltd, 1996), p78-9.

¹⁶ Roger Cooter, 'The Ethical Body'.

¹⁷ David J. Rothman, *Strangers at The Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991), p245-6.

Nevertheless, rights based strategies in mental health and medicine generally, may be considered to have achieved some change that cannot simply be reduced to New Right economics, and the multi-disciplinary professionalization of medical ethics. And in terms of Nikolas Rose's critique of the rights approach pursued by MIND in the 1980's, one legal rights protagonist was surely correct when he countered that:

...neither the origins nor the character of these rights should allow us to lose sight of their intrinsic value. Whilst they may not often affect substantive outcomes, they do open up areas of the psychiatric system to scrutiny which might otherwise remain hidden, and they require those who operate the system to reflect on and justify what they are doing. ... When reminded by Rose 'of the limited nature of law and legal mechanisms *vis-à-vis* other mechanisms of organizing, monitoring and transforming social provisions' we are surely entitled to ask what these 'other mechanisms' are before baby and bathwater disappear together.¹⁸

And it is here, I believe that the key to understanding Rose's 'radical' constructionist critique lies. For Rose, in fact, proposes no potential alternative means for transforming social provision. Instead he offers only vague and tentative suggestions. It is these suggestions that are most illuminating of his argument. It should be emphasized, here, that, whilst Rose makes use of Marxist and socialist criticisms of rights concepts, he himself elsewhere rules out historical research and political strategies based on these philosophies because, he argues, they reduce the means of social regulation to the state in the interests of capitalism, and view power in terms of

¹⁸ Phil Fennell; 'Law and Psychiatry, p59.

its repressive nature on subjectivity. Rose, in contrast, utilizes Foucault's notion of governmentality and of power as productive of 'the self'.¹⁹ So what is it about bourgeois liberal individualism and its market governed by free contracts that is most problematic for Rose? I attempt to confront this in the next section.

A History-less 'Self' is a Threat to the Moral Order.

Humanity is always sufficiently diverse and obstinate to provide endless fodder for moral watchdogs, police, crusaders, vigilantes and entrepreneurs – if only because, once moral crusaders start moralizing, a section of humanity will, thank goodness, resist them just for the sake of it.²⁰

From his very tentative suggestions for alternatives to the notion of rights for psychiatric reform it seems clear that what is primarily problematic about the deployment of rights based political strategies is, not that at root they fail to fundamentally challenge, and indeed might appear to support, the unequal and exploitative social relations of the bourgeois liberal market economy. Instead, it appears that it is primarily the fact that the concept of rights, is a concept evacuated of history, and one that mirrors the history-less condition of 'the self' in modern society. This history-less condition is both vulnerable to a degeneration of the moral order, and dangerous in that it promotes such degeneration. Rose suggests, not so much a political critique of either psychiatry or rights, but a moral one of people in society as a whole. He conceives critiques of psychiatric practice, and the correlative promotion of the subjective experience of people with mental troubles, in a wider and moral

¹⁹ For an example of where Rose rules out these approaches and also provides a description of the notion of governmentality see, Peter Miller and Nikolas Rose, 'The Tavistock Programme', *Sociology* 22 2 171-192, May 1988, p173-174.

²⁰ Colin Sumner, *The Sociology of Deviance: An Obituary* (Buckingham: OUP, 1994) p217

light. In one key passage of his critique of the rights approach to mental health he asserts that the 'rights discourse is incapable of providing authoritative solutions to the problems of our contemporary fragmented moral order.'²¹ We should note here that a purported crisis of the moral order of society was not the target of the civil rights approach. But for Rose there has clearly been a breakdown in the moral binding of society. And we might also recognize that, just as rights arguments could be, relatively easily, appropriated by the New Right for the purposes of acquisitive individualism, and market 'choice', it is likewise not difficult for such views of moral fragmentation to slide into elision with conservative lamentations about the demise of traditional authority and responsible character. In his footnote to this statement about the moral order Rose directs his readers to, what he terms 'the best book' on these matters, *After Virtue*, written by Alasdair MacIntyre.²² MacIntyre is a moral philosopher and the thesis of his work is illuminating of Rose's position.

MacIntyre claims that, in western liberal societies, morality is in a 'state of grave disorder.' Indeed morality and civility are in a condition of 'barbarism and darkness' akin to that exemplified by the collapse of the Roman empire. For him the task in contemporary society should be to attempt to construct forms of community 'within which civility and the intellectual and moral life can be sustained through the new dark ages which are already upon us.'²³ MacIntyre bases this gloomy and elitist contention, in fact, on an old debate in moral philosophy about how and whether moral judgements can be rationally grounded. MacIntyre claims that the doctrine of emotivism enunciated by some philosophers in response to this debate, though it has been heavily criticized in philosophy, has in fact survived to provide the very basis of

²¹ Nikolas Rose, 'Unreasonable Rights, p212.

²² Alasdair MacIntyre, *After Virtue: A Study in Moral Theory* (London: Duckworth, 1981)

²³ Alasdair MacIntyre, *After Virtue*, p244-245.

the modern liberal moral order itself. He describes emotivism as the principle that 'all evaluative judgements and more specifically all moral judgements are *nothing but* expressions of preference, expressions of attitude or feeling, insofar as they are moral or evaluative in character.'²⁴ And he claims that people in our society have come to 'think, talk, and act *as if* emotivism were true...'.²⁵ This is, what he calls, a 'liberal democratization of moral agency' which, for MacIntyre, means that 'anyone can be a moral agent'. MacIntyre clearly considers this a retrograde step. He is unspecific, however, about what *would* qualify a person – such as himself – for this evidently onerous task of social responsibility. (One presumes it would entail an appreciation and acceptance of the particular form, and import, of the past which *he* outlines for 'us').

Now, significantly for my discussion of Nikolas Rose's attack on rights, MacIntyre makes plain that the underlying problem with 'the self' in modern western society is that it is history-less.²⁶ The 'democratised self', he says, has no history, it is 'in and for itself nothing', and so it can moralise on everything.²⁷ As an example he contends that protest has become simply 'indignant self-righteousness' which is, 'now almost entirely that negative phenomenon which characteristically occurs as a reaction to the alleged invasion of someone's rights in the name of someone else's *utility*'.²⁸ This is a moral world, according to MacIntyre, in which, 'I am what I choose to be'.²⁹ But in such a world where moral judgement is nothing but personal preference, isolation and self-absorption are the ultimate price of having to rely on one's own self-sufficient

²⁴ Alasdair MacIntyre, *After Virtue*, p11. Italics in the original.

²⁵ Alasdair MacIntyre, *After Virtue*, p21. Italics in the original.

²⁶ This is my own term for the description of the individual in modern society that MacIntyre elaborates.

²⁷ Alasdair MacIntyre, *After Virtue*, p30.

²⁸ Alasdair MacIntyre, *After Virtue*, p68.

²⁹ Alasdair MacIntyre, *After Virtue*, p205.

morality. Self-indulgence, emptiness and boredom become amongst the representative attributes of our modern existence.³⁰ For 'the self' to be without history, according to MacIntyre, is to be both vulnerable and dangerous. But for MacIntyre:

We are, whether we acknowledge it or not, what the past has made us and we cannot eradicate from ourselves ... those parts of ourselves which are formed by our relationship to each formative stage in our history.³¹

Such a claim should sound familiar. This is exactly the kind of statement that mental hygienists originally based their attempt to apply a form of moral therapy for the community on. And MacIntyre's further contentions are also similar. Having expounded what he claims such formative stages to be, and propounded the necessity to return to some version of the Aristotlean virtues and 'heroic society', MacIntyre contends that to separate oneself from such morality, practice and tradition, as the modern 'self' has been brought to do, entails a lapse into amoral self-sufficiency:

To cut oneself off from shared activity in which one has initially to learn obediently as an apprentice learns, to isolate oneself from the communities which find their point and purpose in such activities, will be to debar oneself from finding any good outside of oneself. It will be to condemn oneself to ... moral solipsism.³²

MacIntyre maintains that three defining 'characters' exemplify the current manifestation of emotivism as the principle of 'the self' in modern society. These are

³⁰ Alasdair MacIntyre, *After Virtue*, p21, 25, 26-7, 70-71, 108, 240-241.

³¹ Alasdair MacIntyre, *After Virtue*, p122.

³² Alasdair MacIntyre, *After Virtue*, p240.

the Aesthete, the Manager and the Therapist. All embody the historically evacuated nature of 'the self' and its amorality. The Manager is related to the sociologist Max Weber's description of bureaucratic rationality, which MacIntyre describes as conceiving people as means towards efficiency and never ends in themselves. The Aesthete is related principally to Nietzsche's solipsistic 'superman'. And finally the Therapist. The Therapist stands as the main Character to apply emotivism, and the obliteration of history, to personal life.³³ The Therapist has replaced 'truth' as a value, according to MacIntyre, with 'psychological effectiveness'. And, indeed, the idioms of therapy have permeated society, even though the standard therapeutic theories have, according to MacIntyre, been authoritatively undermined.³⁴ The reason for this continued influence, he maintains, is largely that the Therapist embodies and furthers contemporary emotivist and history-less moral fictions.

MacIntyre explicitly correlates rights discourse with the evacuation of history from 'the self' in western modernity and 'the self's' consequent amoral solipsism. He emphasizes that concepts such as rights are 'pseudo-concepts', they have no history and cannot be grounded.³⁵ It is this vision which Rose associates himself with. This is the crucial significance of rights to Rose; it is that their ahistorical insubstantial essence perfectly mirrors that of the modern 'self'.

But it is astonishing that such characterizations of isolation and loneliness can so simply be attributed to an apparently willful emotivism amongst the populace and the profound influence of the psy disciplines. Without entirely ever ruling them out, the

³³ Alasdair MacIntyre, *After Virtue*, p29-30 and 71.

³⁴ Alasdair MacIntyre, *After Virtue*, p29 and 71.

³⁵ Alasdair MacIntyre, *After Virtue*, p64-68, 240.

economic, the political, and the corporeal are circumscribed.³⁶ What of the multitudinous effects of a thoroughly unequal society? What of the effects of health problems? Of poverty? Of discrimination? Of power relations in a hierarchical society? Neither Alasdair MacIntyre nor Nikolas Rose ever really grapple with them.³⁷

The continuities with Rose's views regarding the rights approach to mental health are clear. Take the following statement, for example, where again Nikolas Rose directs us in a footnote to MacIntyre's thesis:

It is a sign of the times that one has to remind oneself that it is possible to think of an ethics without rights, perhaps framed in a language of duties and obligations, of social support given not because it is a right, but because it would be virtuous to give it, or politically correct to give it, or because it would make the giver a better person. It is worth remembering that other grounds for morality exist than those in which humans are to be valued only in so far as they get what is due to them.³⁸

This last comment is hardly representative of MIND's work. But what Rose calls the 'self-righteous' discourse of rights is nevertheless, on his view, complicit in the fragmentation and deterioration of the moral values of the populace. Where rights activists targeted what they saw as inequalities of power and treatment in the psychiatric system and attempted to redress them, Rose suggests, instead, that fears

³⁶ A particular irony since MacIntyre an ex-member of the Communist party, and an ex-Trotskyist, has claimed that, though Marxism's moral critique is redundant, its political critique is still useful.

³⁷ Questions, by contrast, not lost on MIND in the 1970's and 80's, and indeed in the present day. See, *Connections* MIND Quarterly Newsletter, Summer 2004.

³⁸ Nikolas Rose, 'Law, Rights and Psychiatry', p211.

about a crisis of the moral order and an apparent amorality amongst the populace should constitute the primary target. Rose continues this fundamental theme in his subsequent writings. On the impact of psychotherapy in the construction of 'the self', for example, he writes:

It is the self freed from all moral obligations but the obligation to construct a life of its own choosing, a life in which it realizes itself.³⁹

It is quite amazing that the major troubles of society are reduced to a selfish and solipsistic self-indulgence brought about by the apparently one-way and irresistible power of the psy disciplines. Lack of economic equalities of power or of meaningful popular democracy do not enter into it. Moreover, despite the apparently radically critical pretensions of this strong constructionist critique of notions of 'the self', it should be emphasized that such fears for the moral order of society are themselves a quintessential aspect of that same 'transformation of social and intellectual rationality' that, Rose emphasizes, gave birth to bourgeois liberal individualism. If the legal rights strategy pursued towards the end of the twentieth century is illegitimate because of its close associations with the rise of bourgeois individualism, then this concern over a lack of moral fidelity in the community must also be unsound.

³⁹ Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Routledge, 1989), p254.

Social Construction *Versus* 'Strong' Social Construction.

Nikolas Rose's critical history of the psy disciplines can be understood as essentially developing a historical critique of one of the three 'characters' that MacIntyre portrays as typifying the emotivist nature of the modern 'self'. For Rose it is the 'Therapist', in the guise of the psy disciplines, that has fundamentally informed this transformation. Before I discuss this directly however, I want to elaborate the principal difference between my own understanding of social constructionism and, what I have termed, 'strong' social constructionism, represented by Nikolas Rose and David Armstrong.

Ian Hacking has recently analysed social constructionism, seeking to investigate its import by clarifying the point of its use.⁴⁰ Social constructionist approaches, he observes, are critical of the status quo. He provides us with a schema for understanding this. Such approaches, he says, tend to hold that 'X' (the point of study) need not have existed as it is at present, 'it is not determined by the nature of things; it is not inevitable. 'X' was brought into existence or shaped by social events, forces, history, all of which could well have been different'.⁴¹ X for Hacking stands for our *ideas* about something. It is precisely when these ideas about something are taken for granted, that is appear to be inevitable, (condition 'O' in Hacking's schema) that attempts might be made to show that they are socially constructed.

In the realm of medicine and psychology, a number of valuable analyses of knowledge claims on various topics such as schizophrenia, sexual dysfunction and IQ

⁴⁰ Ian Hacking, *The Social Construction of What?* (Cambridge Massachusetts : Harvard University Press, 1999)

⁴¹ Hacking : *Construction of What?*, p6-7

have emerged in recent years from this social constructionist perspective.⁴² Similarly, for Rose, condition 'O' appears to be fulfilled. He can claim to be arguing, not only against a political discourse which sees people in terms of atomistic pre-social selves but against, what he presumably sees as, a prevailing paradigm in psychology that sees subjectivity as structured by a 'multi-layered psychic architecture in which self-contained psychological entities fight it out on the battleground of mental life'.⁴³ As such he can be seen as challenging the acceptance of these ideas as predetermined by the nature of things.

But, Rose has himself castigated such a social constructionist stance for being naive.⁴⁴ He has maintained that 'the claim that "x is not given in reality, but socially constructed" ', in fact, preserves the 'maintenance of an ideal of truth as that which *would be* grounded in the empirical'.⁴⁵ According to Rose it saves positivism and empiricism. It maintains a vision of a pre-given reality that knowledge could one day come to know.

But Nikolas Rose is misconstruing, both the utility of social constructionist accounts, and their ultimate logic. It is not the case that social constructionist accounts can only base their critical impact on the basis of retaining a notion of an objective reality that constitutes truth. On the contrary, though he eschews positivism or empiricism, this is what Rose ends up doing. The utility of social constructionism is that it opens up a

⁴² See for example Mary Boyle, *Schizophrenia : A Scientific Delusion?* (London : Routledge 1990); Mary Boyle, 'Gender, Science and Sexual Dysfunction', in Theodore R Sarbin and John I Kitsuse (eds) *Constructing the Social* (London : Sage Publications, 1994); Milton L Anderson, 'The Many and Varied Social Constructions of Intelligence' in Theodore R Sarbin and John I Kitsuse (eds) *Constructing the Social*.

⁴³ Harré & Gillett : *Discursive Mind*, p181

⁴⁴ Nikolas Rose, *Inventing Our Selves*, p49-52.

⁴⁵ Nikolas Rose, *Inventing Our Selves*, p51 and p52. (Italics in second quote from the original).

space between 'nature' or 'reality' and theories about it. This can allow for competing views to be heard. But what is crucial is that any competing views, in as much as they attempt to provide an alternative rendition of what this 'nature' is, are themselves open to further social constructionist critique. These arguments are open to critique precisely when they presume to close the gap between 'reality' and their knowledge of it. Thus the phrase: 'That is the way it is', should be an incitement to a social constructionist. In terms of its utility, social constructionism, if it *does* suggest a truth of its own, suggests a minimal one, that our *knowledge* of 'reality' is *never* unmediated. Its import then is that it challenges hubris by the acknowledgement of doubt. Intellectual knowledge is *never* sufficient to *explain* 'nature', and thus there is no hope held out of 'truth as that which *would* be grounded'. It suggests that all the knowledge we have (and ever will have) is both provisional, and a form of power relation. Social constructionism only makes sense when it is used as a tool to show such gaps between knowledge and 'reality'. It does not make sense as an *explanation* of 'reality'. To do so is to colonise the 'gap' all over again. This is exactly what Rose does. Instead of seeing that social constructionism is a tool that can reveal the uncertainty of knowledges that claim to explain 'nature' (which includes what we are told constitutes 'us'), Nikolas Rose makes social constructionism an explanation. He makes his own objective knowledge sufficient to explain 'nature'. 'Nature', to him is that which is socially constructed. There is no gap here. Intellectual knowledge has been made sufficient unto 'nature'. Knowledge of the forms of 'social recognition' of 'the self', and the 'nature' of 'the self' itself, have become one. The 'nature' of 'the self' has become dissoluble with objective knowledge about it. Thus, Rose maintains: 'The self does not pre-exist the forms of its social recognition.'⁴⁶ Somehow knowledge

⁴⁶ Nikolas Rose, *Governing the Soul*, p218.

about 'nature' has become unmediated. This is what happens when social constructionism is made to perform a task that it cannot, and should not, undertake. What is of key importance is *not* to claim definitively that some aspect of our understanding of 'nature' *is* a social construction, but that the *knowledge itself* is amenable to explanation in terms of construction in the social world. Nikolas Rose is fighting the wrong problem. The problem is not that we do not have sufficient objective knowledge of 'nature' which he claims to have rectified by showing that the essence of 'nature' is its constructedness. On the contrary, the problem is to *constantly* recognize that *all* explanations of 'nature' are mediated and thus insufficient to it.

Ironically then, it is Rose himself who holds out that knowledge about 'nature' can be grounded. But contrary to Rose's assertion, social constructionism does not, and cannot, hold out a vision of 'nature' which suggests that it *could*, ultimately, be intellectually grounded. The point is to open up spaces, ruptures and contingencies. But it becomes just another suffocating and de-legitimizing 'truth' about 'us' if it is then made to become an *explanation* of ourselves. To do so is simply to swap one apparent certainty for another. Such a stance is radical, but only in the sense that it attempts to overthrow one apparently sanctified authority about 'us' and replace it with another one. This strong social constructionism does not place under attack what it should. What ought to be attacked is the privilege accorded one-way psychological descriptions of people's individual character and experience. It does not place into question the kind of one-way reason that defines others and allows them no response except in terms of the definition that has been provided for them. Instead this strong constructionism performs its own one-way reason. For it, the psy disciplines'

understanding of 'the self' is to be criticized in so far as its objectivity is *insufficient*. These social constructionist theorists of 'the self' claim to be *more* objective and thus their one-way reason is more accurate. Thus, Rose does not criticize the purported psychological 'discovery' of an 'inward-looking, isolated, self-sufficient individual' because it is a privileged one-way description that claims objective knowledge of the person and his or her experience. Instead he criticizes it for the insufficiency of this description. It is insufficiently objective. "'The self' does not pre-exist the forms of its social recognition',⁴⁷ claim the strong social constructionists, and thus psy knowledge is insufficiently objective in its description of 'the self' because it does not recognize this 'true' nature of 'the self'. The psy disciplines have got it wrong and the strong social constructionists have got it right.

But this strong constructionist statement that ' "'The self" does not pre-exist the forms of its social recognition.' is, I believe, highly problematic. This is revealed more clearly if it is rephrased as a question: Does 'the self' pre-exist the forms of its social recognition? The answer must be that the question is unanswerable. To answer it is to perform a type of 'social recognition'. I take it that Rose would not argue that individuals are anything other than always and already 'social' (ie inseparable from their social context). However, this statement does not logically show that social context constitutes human ontology. If we are inevitably socially located, this in itself says nothing about our ontology; it simply shows that human knowledge and experience is inescapably part of social context. Even an apparently individual (subjective) answer cannot therefore be anything other than a social recognition. And if 'social recognition' is unavoidable, whether one supplies positive or negative

⁴⁷ Nikolas Rose, *Governing the Soul*, p218.

answers to the question ('yes "the self" is pre-existent' or 'no "the self" is not pre-existent') then it cannot be used to determine which answer is correct. To answer it, as Rose does, by denying that 'the self' can pre-exist social recognition, is simply to fall into an equal and opposed error to that of asserting that 'the self' *can* pre-exist social recognition. The question cannot be satisfactorily answered intellectually. The craving for certain intellectual knowledge of 'the self' cannot be so easily appeased.

History cannot be introduced as an independent means to show that 'the self' is constructed and the 'significant' ways in which this takes place.

[Modernism has] 'long been the water in which the ordinary intelligentsia, goldfish-like, has swum – and as everyone knows, "Fish are the last to discover water".'⁴⁸

But Nikolas Rose's argument, in fact, relies on a restricted interpretation of 'social recognition', conceived as those that are constitutive of 'the self'. In his view, it is only certain knowledges and practices that make up the forms of 'social recognition' that constitute 'the self'. If Rose attempts to justify his definition of the 'real' (which includes 'the self') as constructed, largely on philosophical grounds, he cannot justify his further contention of the particular present form this construction takes, nor the pre-eminence of the psy disciplines in this construction, on the same basis. For this he turns primarily to history. However, this simply adds a further layer to the problem I have outlined.

⁴⁸ Joanna Overing, *Reason and Morality*, (London: Tavistock, 1985), 47-70, p49.

As I mentioned earlier, Rose's critical history of the psy disciplines can be understood as essentially developing a historical critique of MacIntyre's 'Therapist'. For Rose it is the psy disciplines that have fundamentally informed this transformation. And he describes this in terms of a construction of our very selves. Rose's critical history contends that, far from the research and practice of the psy disciplines coming closer to foundational knowledge of 'the self', they have in fact been key to 'the self's' construction. For Rose constructions of 'the self' are not to be accepted as 'given' but historically understood by investigating the 'complex of apparatuses, practices, machinations, and assemblages within which human being has been fabricated.'⁴⁹ 'Apparatuses' here mean such sites as the family, the factory or the prison. 'Assemblages' are 'specific domains of action and value' where certain routines and techniques are localized and connected together.⁵⁰ Such a critical history of the psy disciplines thus becomes a history of the construction of 'our contemporary regime of the self'.⁵¹ As we have seen, for Rose, 'The "self" does not pre-exist the forms of its social recognition.'⁵² Following Foucault, he emphasizes the heterogeneity of connections between the government of others and the government of 'the self'. Rose contends, however, that the heterogeneity of these inter-connections has undergone 'a certain levelling' in contemporary society. In terms of the contemporary liberal western world, he argues, we may talk in terms of a single regime of 'the self'. His justification for speaking of such a regime, whilst emphasizing its heterogeneous nature, is that there is a 'family resemblance' in the regulative ideals that are at work in the diverse practices which act on human beings.⁵³ There is a 'common normativity'

⁴⁹ Nikolas Rose, *Inventing Our Selves: Psychology, Power, and Personhood* (Cambridge: Cambridge University Press, 1996), p10.

⁵⁰ Nikolas Rose, *Inventing Our Selves*, p38 and 61.

⁵¹ Nikolas Rose, *Inventing Our Selves*, p39.

⁵² Nikolas Rose, *Governing the Soul*, p218.

⁵³ Nikolas Rose, *Inventing Our Selves*, p2-3, p39.

of the 'quotidian yet sovereign self of choice, autonomy and freedom', which has been constructed out of these diverse and contingent, practices and problems.⁵⁴ Rose thus employs history as an objective means to show that the 'human technologies' of the psy disciplines have been key to the construction of 'the desiring, relating, actualizing self' in the later twentieth-century.⁵⁵ It is psy which has come to assert an understanding of the internal mechanisms of human behaviour and which therefore claims the essential underpinnings of knowledge, judgement and techniques with which all experts of the government of conduct must operate.⁵⁶ Indeed Rose goes so far as to claim that '*the very meaning of life*' in modern liberal democracies has been 'made possible by, and shaped by, the modes of thinking and acting' of the psy disciplines. And, crucially for Rose, psy, he claims, has 'infused the shape and character of what we take to be liberty, autonomy, and choice in our politics and our ethics', 'in the process freedom has assumed an inescapably subjective form.'⁵⁷

Rose, thus uses history to show that we have become, in effect, constituted as history-less – that is, apparently self-generated subjectivities whose concept of the past lacks history in the sense of an objective appreciation of our situation within its structure.

In an analysis of the role of the Tavistock Clinic in the psychologization of subjectivity Rose and his co-author Peter Miller highlight that their analysis 'emphasises the constitutive role of knowledge.'⁵⁸ They contend that subjectivity itself cannot be regarded as the basis for evaluating the substance of social regulatory systems. They continue: 'The regulatory systems with which we are concerned are

⁵⁴ Nikolas Rose, *Inventing Our Selves*, p3.

⁵⁵ Nikolas Rose, *Governing the Soul*, pxii.

⁵⁶ Nikolas Rose, *Inventing Our Selves*, p12-13

⁵⁷ Nikolas Rose, *Inventing Our Selves*, p16 (my italics).

⁵⁸ Peter Miller and Nikolas Rose, 'The Tavistock Programme', p174.

intrinsically dependent upon particular ways of knowing. For something to be manageable it must first be knowable.⁵⁹ I shall later question this 'constitutive role' of intellectual knowledge from another angle. But, here, I want to show that, if Rose and Miller are to make such a claim, then the bases upon which they found their constructionist account of the creation of the modern 'self' must also be considered in this light. This means that both history as 'objective knowledge' and intellectual knowledge itself require to be analyzed in the same terms.

The past is a phenomena that, following Rose's constructionist principle, must also necessitate being made intellectually knowable before it can be managed as 'history'. And further, also following Rose's argument, this management must be considered, neither as a mystification nor as a revelation of the past, but as a construction.

Following the logic of such a strong constructionist argument, history itself must be conceived as a regulatory practice that participates in the construction of 'the self'. If 'the self' is neither discovered nor mystified but constructed it also follows, therefore, that those professions which describe and outline the past as 'history' are not revealing aspects of the past but in fact constructing them. And if this is the case, then strong social constructionists cannot claim to be revealing by means of history the significant ways in which the contemporary 'subject' has been constructed without throwing into question their whole enterprise.

Such strong social constructivists who delineate how the 'subject' has come to be fabricated, or how we have become 'who we are', seem curiously reluctant to consider themselves and their knowledge to be caught in the problematic they outline. It is as

⁵⁹ Peter Miller and Nikolas Rose, 'The Tavistock Programme', p174.

if they believe that their own categorizations, outlines and hierarchies of history, remain somehow separate from the processes of construction that they claim to illumine. As a direct means to show this I set out below some passages from consecutive pages written by Nikolas Rose describing how psychological research has constructed knowledges and practices of 'the self' rather than come closer to revealing intrinsic aspects of our nature. All of these passages could be persuasively re-written substituting the historian for the psychologist and the past as the object of study instead of the child:

For the psychologist, as for scientists elsewhere, inscriptions have a number of advantages over their subjects themselves. ... Children are difficult to accumulate in large numbers. Large rooms and considerable labour are required to hold them side by side, to pick out common or differentiating features. They change over time. Once dismissed from the laboratory it may be impossible to reassemble them for further examination. Only a limited number of observers can view them and thus be convinced of the value of what the psychologist has to say about them. They are unstable material for the scientist to work on.⁶⁰

And they [the children] could then be arranged in a visual display that summarized and condensed the multifaceted actions of the children into a single array that could conveniently be deployed within scientific debate, in articles, textbooks, and teaching materials.⁶¹

⁶⁰ Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Routledge, 1989), p144.

⁶¹ Nikolas Rose, *Governing the Soul*, p144.

The distance from the squalling, troublesome, and undisciplined infants of the laboratory, to these calm ordered, and disciplined frames is considerable. We should not, however, think of this as movement on a dimension from the concrete to the abstract. Indeed quite the reverse. These images are far more concrete, far more real than the child itself. Children are ephemeral, shifting, elusive, changing before one's eyes, hard to perceive in any stable fashion. These images make the child stable by constructing a perceptual system, a way of rendering the mobile and confusing manifold of the sensible into a legible visual field. ... The forms of knowledge have, in a crucial sense, merged with the object itself.⁶²

The object so produced had ... become docile; it had internalized the norms of the scientific programme in the very form of its inscription. ... Non-intellectual behaviour was thus rendered into thought, disciplined, normalized, and made legible, inscribable, calculable.⁶³

We should not think of these procedures of inscription as merely allowing the documentation of a familiar reality – the developing child – in a more convenient form. ... Techniques for visualizing and inscribing individual differences transform the intellectual universe of the scientist and the practical universe of objects and relationships to which things can be done. In short, technical developments make new areas of life practicable.⁶⁴

⁶² Nikolas Rose, *Governing the Soul*, p146.

⁶³ Nikolas Rose, *Governing the Soul*, p146 and 147.

⁶⁴ Nikolas Rose, *Governing the Soul*, p149.

All who had dealt with children in their professional or personal life could now have their mind instructed through the education of their gaze.⁶⁵

History does not provide us with an independent means to judge the normative impact of what are called the psy disciplines. If it is to be claimed that the psy disciplines have been pre-eminent in the construction of our very selves, history cannot be utilized as the objective means to justify this contention.

It is important to be clear about this. Rose could make the counter-claim that his descriptions of the pre-eminence of the psy disciplines in our construction are merely tentative and fabricated counter-histories intended to disrupt, as Foucault would have put it, 'the consoling play of recognitions.'⁶⁶ There would appear to be support for this in that, following Foucault, Rose makes use of the Nietzschean concept of genealogy. The latter's notion of genealogy was a means to suggest that what appears to people in the present as sanctified truth and knowledge – Nietzsche particularly targeted fundamental moral beliefs - can be shown to have a history. The linkages of truth, knowledge and morality were all being questioned here. But Rose attempts to deploy this notion of genealogy without paying sufficient regard to Nietzsche's equally important notion of perspectivism.⁶⁷ Since, for Nietzsche, knowledge and thinking was inescapably down to interpretation and perspective, his thinking was intended to be provisional and provocative, taking multiple perspectives. But the strong constructionism espoused by Rose and Armstrong, can hardly be seen as embodying

⁶⁵ Nikolas Rose, *Governing the Soul*, p149.

⁶⁶ Michel Foucault, 'Nietzsche, Genealogy, History' re-produced in, Paul Rabinow (ed) *The Foucault Reader* (Harmondsworth: Penguin, 1991), p88.

⁶⁷ Foucault, on the other hand, appears to have accepted the importance of Nietzsche's notions of genealogy and perspectivism. On perspectivism see, Michel Foucault, 'Nietzsche, Freud, Marx' in, Gayle L. Ormiston and Alan D. Schrift (eds), *Transforming the Hermeneutic Context: From Nietzsche to Nancy* (New York: State University of New York Press, 1990) 59-67.

this. It would be difficult to accept any idea that what is being offered is tentative, and only one of the multitude of ways in which one could take a perspective on such issues. In the first place, what is not allowed to be perspectival is the 'fact' that 'the self' is constructed. In the second, this authoritative assertion has been continually, and dogmatically stated, along with the concomitant assertion that the psy disciplines (or in Armstrong's case, medicine in general) have been pre-eminent in fabricating the 'sovereign self of choice, autonomy and freedom', for the past twenty years.⁶⁸

This is shown clearly in David Armstrong's most recent book.⁶⁹ At the beginning of his final chapter Armstrong appears to acknowledge that his rendition of the past must, according to his stance, itself be a construction. But, rather than exploring the full ramifications for his constructionist claims about medicine and 'the self', he claims to show that his methodology avoids the problem of the gap between the events of the past and their objective interpretation as history. Armstrong emphasizes the traditional problem of an historical enterprise that attempts to differentiate between actual events (pre-text moments) the primary source account of any of these events (primary text) and derivative texts by the historian or other people (secondary sources).⁷⁰ He points out that the pre-text event is inaccessible and that primary and secondary sources are all interpretations. Thus, though historians commonly prioritize texts according to their perceived proximity to original moments, Armstrong emphasizes the fact that these texts embody, 'the encrustation of later times on the supposed pre-textual events that they notionally record'.⁷¹ Since Armstrong's expressed aim is to 'explain Man as the outcome of knowledge and practices', he also

⁶⁸ Nikolas Rose, *Inventing Our Selves*, p3.

⁶⁹ David Armstrong, *A New history of Identity: A Sociology of Medical Knowledge* (Basingstoke: Palgrave, 2002).

⁷⁰ David Armstrong, *A New history of Identity*, p190.

⁷¹ David Armstrong, *A New history of Identity*, p190.

applies this view that all texts are interpretations to medical texts and their object – 'the patient or person'.⁷² The 'empirical world', he tells us, can only be rendered as text and thus, by the logic of the argument, a text is just one more interpretation, one more 'truth claim'. Crucially, Armstrong claims that the only way to deal with the inevitability that all texts are interpretations is to acknowledge that they must all be 'treated as primary, as constructing the world at the time of their publication.'⁷³ This appears to take a perspectivist, non-dogmatic view. But, actually it smuggles in the apparently non-perspectivist 'truth claim' that 'the self' is constructed. The logic goes like this: since all texts are perspectives they cannot be hierarchized according to how close to 'truth' they are. Therefore if none of these texts can access the 'real' they must be considered, in fact, to construct it through their representation. The representation *is* the reality. Thus, Armstrong can elide the medical texts that are the basis of his argument that 'the self' is constructed, with his view that no historical text about the past can be anything other than a perspective that constructs the past at the moment that it tries to relay it. Armstrong is thus able to appear to accept that renditions of the past (including his own) must be constructions, and maintain an apparently perspectivist understanding of knowledge, whilst *simultaneously* retaining that which must not be allowed to be perspectival – the 'fact' that 'the self' is constructed. Thus, having discussed the apparently irresolvable problems of interpretation regarding the past and 'the self', Armstrong is able to continue to claim that subjective agency is to be explained as a construction and an 'historical emergent'.⁷⁴ This manouvre allows him to justify his twenty year old constructionist account of 'the self', and the pre-eminent role of medicine in this, that his work reiterates.

⁷² David Armstrong, *A New history of Identity*, pix and px. Armstrong uses the term 'Man' mainly for the nineteenth century and 'identity' mainly for the latter twentieth century. However he retains 'Man' as a generic term.

⁷³ David Armstrong, *A New history of Identity*, p191-2.

⁷⁴ David Armstrong, *A New history of Identity*, p197.

However, if there are no knowledges (which Armstrong reduces to textual knowledge) that can show themselves adequate to representing 'reality', it does not follow from this that such knowledges *construct* 'reality' (including 'the self'). All Armstrong is doing is closing the gap between the 'real' and knowledges about it. The power relation that is embodied in his own description of both the past and 'the self' is kept out of the picture.

It is important to emphasize that both Armstrong and Rose provide very restricted renditions of how and in what way this construction takes place. Even if we were to allow that 'the self' *is* constructed, neither Armstrong nor Rose can ground these restricted renditions. To take Rose as an example. He maintains that it is only certain knowledges and practices that make up the forms of, what he calls 'social recognition', that constitute 'the self'. He is therefore contending that other forms of social recognition do not perform this task. But if Rose is to claim that *specific* 'social recognitions' are constitutive of 'the self' then he needs to show what is common to all these knowledges and practices such that they make up an objective totality which he calls 'social recognition'. According to Rose some 'social recognitions' either do not, or are in themselves insufficient to, constitute 'the self'. Therefore all 'social recognitions' do not constitute 'the self'. It follows that Rose needs to show which forms of 'social recognition' make up his defined totality of 'social recognition', the forms of which constitute 'the self'. He is unable to do this. I have already alluded to history in this context; why not the historical mode? Why can this not be considered an element of constitutive 'social recognition'? Why not religion?

The Privilege given to intellectual knowledge delegitimizes emotional experience.

An associated problem with this constructionist view of 'the self' is that it suggests a view of human experience in terms simply of an unremitting construction and interpolation of models. It encourages a confrontation with people's experience in terms, not of their expressed experience, but only of an analysis of constructions; of models already pre-supposed to be all there is. Take the following quotation from an article by David Armstrong, which presents this strong constructionist view of 'the self':

The extended medical gaze does not repress the liberty of the individual, but rather creates it. It is only through the extended gaze – within medicine and other agencies – that the psychological and social characteristics of wholeness and identity come to exist for those inert corporal masses which the clinical gaze had fashioned throughout the nineteenth century. It is ironic that having had their subjectivity fabricated those same subjects insist that subjectivity is an invariable and universal component of human life; but it is also a subtle device through which the operation of this power is concealed.⁷⁵

In no way could this be described as empowering of people: In fact it constructs a theoretical discourse at such a pitch of abstract intellectuality that it appears to delegitimize *any* expression of a sense of self and the importance of one's own experience. Not only is it condescending but it is also manifestly untenable as a theory as I have tried

⁷⁵ David Armstrong, 'From Clinical Gaze to Regime of Total Health', in Alan Beattie, Marjorie Gott, Linda Jones and Moyra Sidell (eds.), *Health and Wellbeing : A Reader* (London : MacMillan in assoc with The Open University, 1993), p61.

to show. On such an account we appear to be shells constructed via categorizations, classifications, and descriptions; knowledges providing ways of knowing and acting. For Armstrong, it seems, we are constituted of surfaces of knowledge and nothing else. But, on this basis, what should we make, for example, of the following two letters written in the early 1960's by people detained in mental deficiency hospitals? (I have attempted to remain as true as I can to their handwritten words in this typed text):

Dear Sir,

Please will you look in My Case. I think I am not getting Well at the 5enrith hospitl when I am at the pences time. Please will Ask Docter Vantines. Can I go to BillDon Hostle. I would like to Do 3 Mothens on LicEEs.

Please will you Find out Why they are keeping Me at the 5enrith.

I have away From home Sinces I was ten years Old. My Mother donst want Me.

Pleas will you do all you Can. I am now 20 two years old. From (Name withheld).

Please Write Back as soo as you Can.⁷⁶

⁷⁶ NCCL archive, DCL 238.1

Dear Sir,

I should like you to get me a very nice job where I shall be very happy there I have been at Starcross 9 years that is in 1951 and I havent had a change yet? (means- !) So please could you kindly help me to find me a very good job because I am a very good worker and my name is (name withheld). And my age is 29 years but this april I shall be 30.

So I must close now

Yours truly⁷⁷

Does it make any sense to conceive of these people in terms of the constructionist theories of 'the self' that I have discussed? One might argue, I suppose, that the author of the first letter has come to experience themselves under the medical concept of 'illness', and that the second author similarly experiences themselves in terms of their working efficiency. But surely the 'experience' communicated by these letters is of an altogether different level. It is true that we inevitably project our own present knowledge and experiences onto these texts. And it is true that in re-presenting them (I hope respectfully) I cannot place them in the full context and situation of their day. But these words nevertheless speak – and they speak at an emotional level. To me they speak of hurt, pain, anguish, desperation, and also of hope and trust. But in explaining 'the self' as constructed we are taken away from any attempt to engage with these people's experience. Our intellectual, 'gaze' is directed only to contriving these experiences as elements and examples of a construction of 'the self'. People's experiences are denied because it has been pre-determined by the nature of the

⁷⁷ NCCL archive, DCL 238.1

analysis that they cannot provide any neutral ground upon which to appreciate the 'nature' of 'the self'.

Whose Subjectivity?

"Yes, that's what you think you mean, but we know better".⁷⁸

Nikolas Rose characterized the rights strategy as substantially based upon a 'flawed' sociological theory of 'social control'. He pointed out that: 'Given that any social and institutional arrangements form, shape and constrain human capacities and actions', the discovery of 'control' is hardly surprising'.⁷⁹ But the same argument can be levelled against his own thesis and those of other strong constructionists such as David Armstrong: If one begins by asking; 'how has "the self" been socially constructed?', it isn't surprising that one will find that 'the self' has been socially constructed. This is simply the inverse of pre-supposing that 'the self' is constituted of an internal psyche – and then proceeding to look for ways in which this is the case. This would be perfectly acceptable of course if we were told that this is *one* way of looking at 'who we are' which might be illuminating. But we are not. We are told that this construction *is* 'who we are' – despite the fact that, as I have shown, this 'truth' about 'us' cannot be grounded. The existentialist analyst Erwin Straus remarked of classical psychoanalysis in the 1950's, that the 'unconscious ideas of the patient are more often than not the conscious theories of the therapist'.⁸⁰ It is as if strong social constructionist theorists of 'the self' are performing a similar manouvre, despite

⁷⁸ The psychiatrist J.H. Kahn referring to Irving Goffman's notion of 'the institutional smirk' at, NAMH, *New Ways with Old Problems: Report of the Annual Conference 1969* (London: NAMH, 1969) 20-38, p20.

⁷⁹ Nikolas Rose, 'Unreasonable Rights', p202.

⁸⁰ Cited by Rollo May in, Rollo May, Ernest Angel and Henri F. Ellenberger (eds), *Existence: A New Dimension in Psychiatry and Psychology* (New York: Basic Books, 1958), p5.

denying the essence of a foundationalist unconscious. Either way the 'subject's' experience appears curiously deligitimized.

In the 1970's Foucault argued that classical psychoanalysis could be understood as an attempt to reassert psychiatric power over the 'truth production' of mental troubles.

He maintained that the manouvre that it performed was

... a matter of making the production of madness in its truth as intense as possible, but in such a way that the power relations between doctor and patient are invested exactly in that production; they remain adequate to it and do not allow themselves to be overrun by it, and they keep control of it.⁸¹

In fact this representation is only really apposite to traditional psychoanalysis. This uses medical metaphors to describe, an atomised and individual psyche within which mental illness is held to reside. This is a conceptualization mirrored in treatment. The patient is isolated on the couch, separated from family, friends and neighbours.

Normal interaction between analyst and analysand is precluded, with the former cast as the objective, scientific interpreter.⁸² As I have shown, however, elements of psychoanalysis were complicit in the shifting problematic of mental hygiene from confronting mental troubles as located in the internal emotional economy of individuals to conceiving them as a product of emotional relationships. It has been a part of the aim of this thesis to show that mental hygienists did indeed lose control of this power relation. But, ironically, Foucault's description can well be applied to those who deploy the strong social constructionist definition of 'the self'. Such

⁸¹ Michel Foucault, 'Psychiatric Power', *Michel Foucault, Ethics, Subjectivity and Truth: The Essential Works of Michel Foucault, 1954-1984, Volume One*, (Allen Lane: London, 1997), 39-50, p46.

⁸² Roy Porter, *A Social History of Madness: Stories of the Insane* (London: Phoenix, 1996), p24-5.

authorities are 'truth-producers' of 'the self' rather than madness. But the effect is much the same. To adapt Foucault's words, a space is arranged so that this 'production of truth' will always remain adapted to the power that produces it. In this way the production of truth can never become 'a counterpower that traps, annuls, overturns' that power.⁸³ Such theorists attempt, through this manouvre, to 'ensure an exact fit between truth production' and historical constructionist intellectual knowledge.

But, like psychoanalysis and madness, this exact fit between the forms of social construction that Nikolas Rose outlines, and 'the self' that he claims they construct, cannot in fact be grounded. And, just as with mental hygienist's original deployment of a one-way moral therapy, what is crucially at stake here is a power relation.

According to strong social constructionists, you and I *are* the forms of our social recognition at any given historical moment. And what constitutes and circumscribes any given historical moment, how such moments change over time, and what the social recognitions are at any of these given moments; all of these are to be told *to* us. If they contradict one's own experience of existence, too bad: to talk of one's own personal experience, one's own feelings, one's own reactions to these self-professedly objective descriptions of who and what we are, is merely to confirm the theory. One has become seduced by the psy disciplines and 'been transformed into a variety of passions to discover and realize the identity of the self itself'.⁸⁴ This is truly a one-way reason that brooks no response other than in terms of the definition it supplies. Such social constructionist theorists place themselves in a position of total privilege over

⁸³ Michel Foucault, 'Psychiatric Power', p47.

⁸⁴ Nikolas Rose, *Inventing Our Selves*, p30.

'common' people. This intellectual knowledge of 'the self', as existent solely in the forms of social recognition defined by such theorists, is placed in authoritative contradistinction to any individual person's experience of themselves.

But what is this abstract apparition the modern 'self'? Even the term 'the self' seems disembodied and impersonal. Indeed there is a tendency to feel that it must only ever really refer to somebody else. Nevertheless, the strong constructionist position maintains that it is not just the knowledges through which we understand and conceive of ourselves in the social world that have been constructed (obviously they have); nor that the many ways in which we experience and describe ourselves, to ourselves and others, are necessarily informed and mediated by particular knowledges and practices, at particular times. (This might at least open up a space for discussion over which ways and to what extent this mediation takes place. But let it be said that this debate will be, and should be, endless). It is more than this. The strong constructionist position maintains that who you actually are - your experience, your very personhood - *is* these constructions. You are nothing but the constructions that social constructivists have outlined for you. So when one reads the term 'the self' in such a sense one should perhaps read 'I' in order to remind oneself what is being claimed. Such a definition and its delineations may feel like an abstraction that could not really encompass you but this is exactly what is being maintained. There is no 'self' out there, distinct from you the reader. 'The self' referred to is you.

But, as with all descriptions of 'man', or 'human', this rendition contains a normative and moral critique. Simultaneous with the definition of 'the self' that you are, is the suggestion that any deviation/slippage between this definition of you, and the 'you'

that you express, or claim to experience, clearly represents something faulty about your knowledge and not theirs. Thus, for instance, Rose maintains that the mode of psychotherapy induces 'the self' to speak. It is in this incitement to speak and confess, he argues, that 'the self' itself becomes fabricated. He claims, for example that:

In the subtle communicative interaction of the confessional scene, the expert gently brings the subject into a relation with a new image, an image that appears more compelling because it is their own. ... They become, in the passage through therapy, attached to the version of themselves they have been led to produce.⁸⁵

This is an extraordinarily passive depiction of the 'subject'. Moreover, it also seems highly unreflective given that academics themselves spend literally years in an induction process. What is the version of themselves (and others) that *they* have been led to produce? But, nevertheless, Rose comes to the conclusion that:

The irony is that we believe, in making our subjectivity the principle of our personal lives, our ethical systems, and our political evaluations, that we are, freely, choosing our freedom.⁸⁶

But if you and I do not accept that these assertions represent valid means to tell us who we are and what our condition is, then it is us who are mistaken not him. Indeed, it is difficult to know how one could argue against this without appearing to confirm the theory. In fact, I myself, have been accused of only having the views I have

⁸⁵ Nikolas Rose, *Governing the Soul*, p246-7.

⁸⁶ Nikolas Rose, *Governing the Soul*, p11.

because I illegitimately introduce the 'repressive hypothesis'. This comment simply reveals how difficult it is to make the point that what one is confronting in the strong constructionist position is a power relation that cannot be grounded, without being accused of maintaining that we are all self-generating individuals who somehow exist outside the social world. It should be clear that I am not stating this. Indeed the accusation against me reveals exactly what I am trying to highlight. The subject – 'the self' – you and I - are trapped in an iron cage, unable to curse it for fear of being told we are only re-iterating the illusion of the 'repressive hypothesis'. Strong social constructionism turns everything into its opposite. Nothing is repressed, only ever produced. Nothing is revealed, only ever constructed. But it is not an either or. It is not a matter of knowledge showing that the existential 'self' is either revealed or it is constructed. Neither can be substantiated. At stake, instead, is the issue of this knowledge itself as a power relation.

With strong constructionism, the power and authority hidden in telling 'us' who we are, and what our own experiential existence amounts to, is never the area of scrutiny. It is another one-way reason that seeks only to teach and never to listen. To speak of oneself is to delegitimise oneself before this one-way constructionist frame of reference. This is just another 'eye' that resolutely refuses to reflect upon the fact that it is caught in the frame of its own problematic.

But, the irony is that, if one accepts the full logic of the strong social constructionist position; if one accepts that the 'historical', no less than the 'psychological', the 'medical', the 'ethical', the 'philosophical', cannot be anything other than knowledges and practices that participate in the construction of 'the self', then social

constructionism is revealed as a dog forever chasing its own tail. The intellectual certainty that it craves forever eludes it. The 'truth' it claims to reveal just carries on being constructed. And the ultimate irony is that a consequence of the strong social constructionist position is that, done thoroughly and constantly, the process will draw one ever closer to one's *own* unsettling present existence; to the subjective present that is, that such theorists want to disclaim.